

B.K.S

JOHN ALLEN COMBS JR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

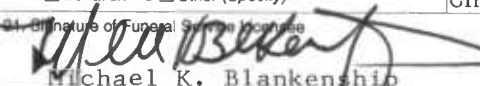

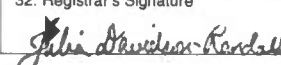
State of Maryland / Department of Health and Mental Hygiene

97 21001

Items: 23a part I, 27, 28a-f per MEO G-749 7/23/97 dh

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Allen Combs, Jr.				2. Date of Death Month Day Year JUNE 11, 1997				3. Time of Death 0718 AM	
	4a. Facility Name (If not institution, give street and number) NAVAL AIR STATION				4b. City, Town, or Location of Death PATUXENT RIVER				4c. County of Death ST. MARY'S	
Funeral Director	5. Social Security Number 217-49-8150		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 1 4		8. Date of Birth (Month, Day, Year) May 7, 1997		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Lexington Park				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 21272 Lexwood Court				10f. Zip Code 20653		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A				16b. Kind of Business/Industry N/A	
	17. Father's Name (First, Middle, Last) John Allen Combs, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Lori Ann Jenkins					
	19a. Informant's Name/Relationship (Type, Print) John Allen Combs, Sr. Father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21272 Lexwood Court, Lexington Park, MD 20653					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Charles Memorial Gardens		Date 6/16/97		20c. Location - City or Town, State Leonardtown, Maryland			
	21. Signature of Funeral Home Director  Michael K. Blankenship				22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. IDIOPATHIC PULMONARY HEMORRHAGE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 6/11/97 found		28b. Time of Injury 6:33 found M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred unknown	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) found at home		28f. Location (Street and Number or Rural Route Number, City or Town, State) 9B Lexwoods, Lexington Park, Md.							
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
State Registrar	29b. Signature and title of certifier  Stephen S. Radentz, MD				29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) JUNE 12, 1997			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) JUN 17 1997		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21002

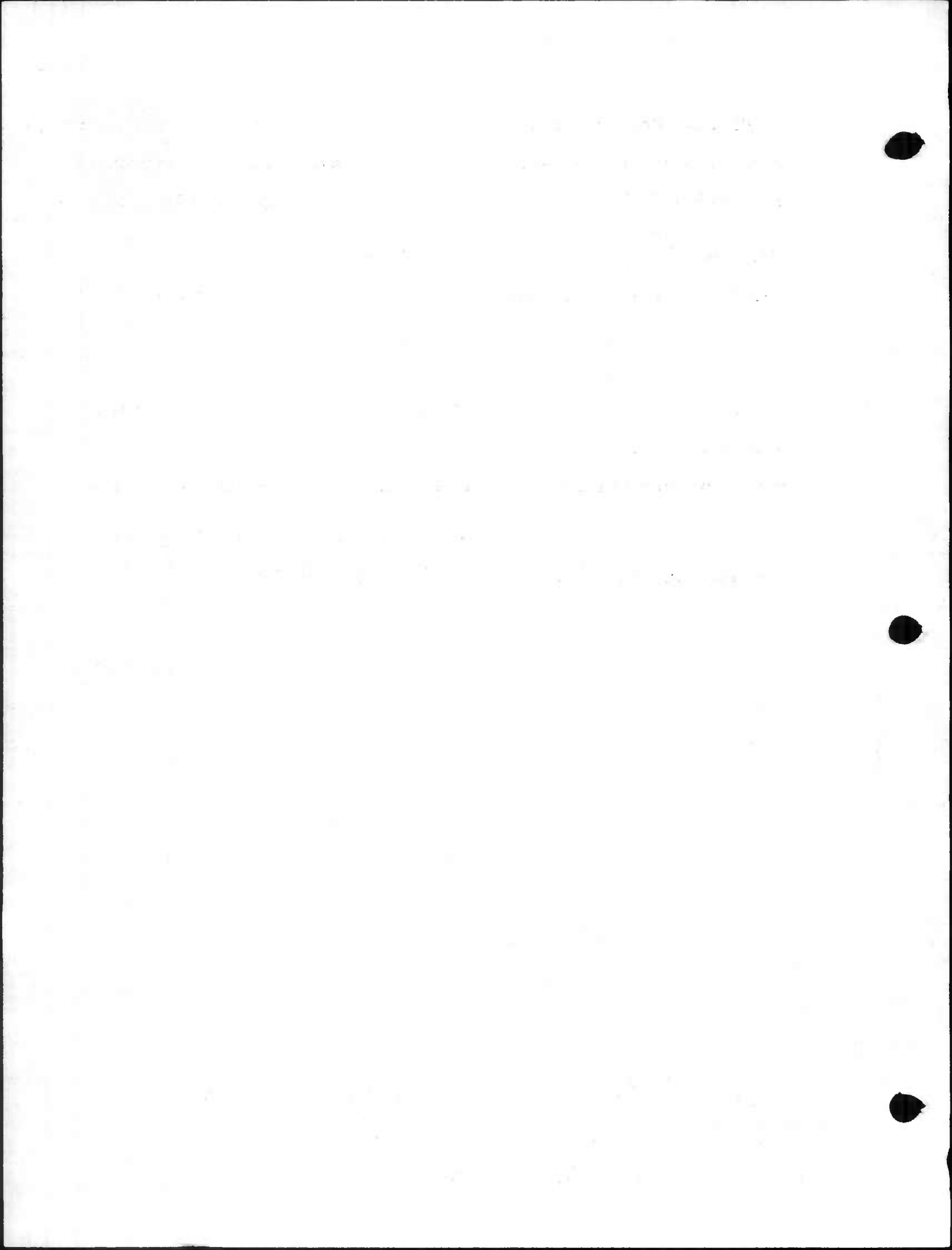
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Martin Gerald Cowley				2. Date of Death Month June Day 30 Year 1997				3. Time of Death 3:00 pm		
	4a. Facility Name (If not institution, give street and number) 6202 Twin Point Cove Road				4b. City, Town, or Location of Death Cambridge				4c. County of Death Dorchester		
Funeral Director	5. Social Security Number 168-30-1308		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 19, 1925		9. Birthplace (State or Foreign Country) Ireland		
	Usual Residence of Decedent										
10a. State Maryland		10b. County Dorchester		10c. City, Town or Location Cambridge				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 6202 Twin Point Cove Road				10f. Zip Code 21613		10g. Citizen of What Country? Irish-American					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Insurance Agent			16b. Kind of Business/Industry Insurance				
17. Father's Name (First, Middle, Last) Jeremiah Cowley				18. Mother's Name (First, Middle, Maiden Surname) Kathleen Clarke							
19a. Informant's Name/Relationship (Type, Print) Judith Piccari - Niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3016 Bedminister Rd., Perkasie, PA 18944							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Hillside Cemetery		Date 7-7-97		20c. Location - City or Town, State Abington, PA			
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613							
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. metastatic carcinoma of unknown primary Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death 2 years							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. chronic obstructive pulmonary disease				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury of Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>[Signature]</i>		29c. License number 039749		29d. Date signed (Month, Day, Year) 7/2/97			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David G Oliver MD 503 Dutchmans Lane Easton MD 21601											
31. Date filed (Month, Day, Year) JUL 3 1997				32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Certificate of Death

Reg. No.

97 21003

Physician /Medical Examiner

Funeral Director

Physician /Medical Examiner

State Registrar

1. Decedent's Name (First, Middle, Last)

2. Date of Death

3. Time of Death

4a. Facility Name (If not institution, give street and number)

4b. City, Town, or Location of Death

4c. County of Death

5. Social Security Number

6. Sex

7. Age (In yrs. last birthday)

8. Date of Birth

9. Birthplace (State or Foreign Country)

10a. State

10b. County

10c. City, Town or Location

10d. Inside City Limits

10e. Street and Number

10f. Zip Code

10g. Citizen of What Country?

11. Marital Status

12. Was Decedent Ever in U.S. Armed Forces?

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

14. Race - American Indian, Black, White, etc.

15. Decedent's Education (Specify only highest grade completed)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

18. Mother's Name (First, Middle, Maiden Surname)

19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

23b. Did tobacco use contribute to the cause of death?

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

25. Was case referred to medical examiner?

26. Place of Death (Check only one)

27. Manner of Death

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21004

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Shirley

Michals

Chaillet

2. Date of Death

Month Day Year
June 28, 1997

3. Time of Death

3:30pm

4a. Facility Name (If not institution, give street and number)

6108 Arbroath Drive

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

405-26-1516

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 11, 1926

9. Birthplace (State or Foreign Country)

Kentucky

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Clinton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6108 Arbroath Drive

10f. Zip Code

20735

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Adam Michals

18. Mother's Name (First, Middle, Maiden Surname)

Charlotte Worden

19a. Informant's Name/Relationship (Type, Print)

James R. Chaillet (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6108 Arbroath Drive Clinton, Maryland 20735

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Resurrection Cemetery

Date

July 2, 1997

20c. Location - City or Town, State

Clinton, Maryland

21. Signature of Funeral Service Licensee

Charles L. Belinger

22. Name and Address of Facility

Lee Funeral Home, Inc.
6633 Old Alexandria Ferry Rd Clinton, MD 2073523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Due to (or as a consequence of):

CANCER OF THE PANCREAS

Approximate
Interval Between
Onset and Death

MONTHS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RECENT CEREBROVASCULAR ACCIDENT

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Philip Wisotsky, M.D.

29c. License number

D-18545

29d. Date signed (Month, Day, Year)

JUNE 30, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Philip Wisotsky, M.D. 700 Old Line Centre, # 700 Waldorf MD 20602

31. Date filed (Month, Day, Year)

6/30/97

32. Registrar's Signature

JUL 02 1997 Julia Swisher Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21005

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Nicholas G. Charuhas

2. Date of Death

Month Day Year
June 16, 1997

3. Time of Death

9:45 P.M.

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

578 22 3000

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 31, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Gambrills

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2011 Hunt Cliff Drive

10f. Zip Code

21054

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Owner

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Gust Charuhas

18. Mother's Name (First, Middle, Maiden Surname)

Evangeline Nicholson

19a. Informant's Name/Relationship (Type, Print)

Elvina C. Charuhas

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2011 Hunt Cliff Drive Gambrills Maryland 21054

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Maryland Veterans Cemetery 6/19/97 Crownsville Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Robert E. Evans

22. Name and Address of Facility

Robert E. Evans Funeral Home, Inc.

16000 Annapolis Rd. Bowie Md. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. *Cardiac Failure*
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *Respiratory Failure*
Due to (or as a consequence of):c. *Renal Failure*
Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Henry Canton

29c. License number

D27333

29d. Date signed (Month, Day, Year)

6-16-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Henry Canton MD 2003 Med. Parkway #130 Annapolis Md. 21401

31. Date filed (Month, Day, Year)

JUN 24 1997

32. Registrar's Signature

*John Anderson*State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21006

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) Marguerite M. Curreri				2. Date of Death Month Day Year 6 21 97		3. Time of Death 2:48 PM	
4a. Facility Name (If not institution, give street and number) Prince George's General Hospital				4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince George's	
5. Social Security Number 219 30 0252		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 65 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 2, 1932	9. Birthplace (State or Foreign Country) Maryland
Usual Residence of Decedent							
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Bowie		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 13322 Idlewild Drive				10f. Zip Code 20715		10g. Citizen of What Country? United States	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home	
17. Father's Name (First, Middle, Last) Charles A. Valenti				18. Mother's Name (First, Middle, Maiden Surname) Henrietta J. Brockschmidt			
19a. Informant's Name/Relationship (Type, Print) John Curreri Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13322 Idlewild Drive Bowie Maryland 20715			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery June 24, 1997 Clinton Maryland		Date		20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee <i>Michael L. Bigler</i>				22. Name and Address of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Md. 20715			

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>pulmonary embolism</i> Due to (or as a consequence of): b. <i>myocardial infarction</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 2 days 3-4	
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	

25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)	

29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
---	--

29b. Signature and title of certifier <i>Charles A. Valenti</i>		29c. License number 034403		29d. Date signed (Month, Day, Year) 6/22/97	
--	--	-------------------------------	--	--	--

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32315 Penn. Ln. Bowie MD 20715	
--	--

31. Date filed (Month, Day, Year) JUN 24 1997		32. Registrar's Signature <i>John Andrew Randall</i>	
--	--	---	--

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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10

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21007

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret Alice Davis				2. Date of Death Month Day Year June 16 1997		3. Time of Death 8:25 PM.								
	4a. Facility Name (If not institution, give street and number) St. Mary's Hospital				4b. City, Town, or Location of Death Leonardtown		4c. County of Death St. Mary's								
Funeral Director	5. Social Security Number 170-36-4185		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 89 Yrs.		8. Date of Birth (Month, Day, Year) November 30, 1907								
	9. Birthplace (State or Foreign Country) Pennsylvania														
Usual Residence of Decedent															
10a. State Maryland			10b. County St. Mary's			10c. City, Town or Location Leonardtown									
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No															
10e. Street and Number 43946 Lanedon Drive				10f. Zip Code 20650		10g. Citizen of What Country? United States									
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White								
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry N/A									
17. Father's Name (First, Middle, Last) George William Hatcher				18. Mother's Name (First, Middle, Maiden Surname) Margaret Martha Malloy											
19a. Informant's Name/Relationship (Type, Print) Katherine L. Hatcher, Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 43946 Lanedon Drive, Leonardtown, MD 20650											
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Lloyd Cemetery		20c. Date 6/21/97		20d. Location - City or Town, State Ebensburg, Pennsylvania								
21. Signature of Funeral Service Licensee <i>Edward N. Brinsfield, Jr.</i> Edward N. Brinsfield, Jr. M00052				22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td>a. <i>Acute Renal Failure</i></td> <td rowspan="4"> Due to (or as a consequence of): b. <i>Acute Left Lower Lobe Pneumonia</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. </td> <td rowspan="4"> Approximate Interval Between Onset and Death 1 wk 1 wk </td> </tr> <tr><td></td></tr> <tr><td></td></tr> <tr><td></td></tr> </table>									Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. <i>Acute Renal Failure</i>	Due to (or as a consequence of): b. <i>Acute Left Lower Lobe Pneumonia</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d.	Approximate Interval Between Onset and Death 1 wk 1 wk			
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. <i>Acute Renal Failure</i>	Due to (or as a consequence of): b. <i>Acute Left Lower Lobe Pneumonia</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d.	Approximate Interval Between Onset and Death 1 wk 1 wk												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>congestive Heart Failure -</i> <i>senile Dementia</i>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)												
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)												
28f. Location (Street and Number or Rural Route Number, City or Town, State)															
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. Signature and title of certifier <i>James Boyd M.D.</i>			29c. License number D19917			29d. Date signed (Month, Day, Year) 4/17/97									
30. Name and address of person who completed cause of death (item 23a) (Type, Print) JAMES BOYD M.D. LEONARDTOWN, MD. 20650															
31. Date filed (Month, Day, Year) JUN 19 1997			32. Registrar's Signature <i>John Andrew Randall</i>												

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerMARGARET DAVIS
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

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State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97 21008

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) **WILLIAM HAM DENNIS, SR.** 2. Date of Death Month **JUNE** Day **30** Year **1997** 3. Time of Death **0417**

Funeral
Director

4a. Facility Name (If not institution, give street and number) **PENINSULA REGIONAL MEDICAL CENTER** 4b. City, Town, or Location of Death **SALISBURY** 4c. County of Death **WICOMICO**

5. Social Security Number **217-28-4922** 6. Sex ☒ M ☐ F 7. Age (In yrs. last birthday) **70** Yrs. 8. Date of Birth (Month, Day, Year) **3/23/27** 9. Birthplace (State or Foreign Country) **MD**

Usual Residence of Decedent 10a. State **MD** 10b. County **Worcester** 10c. City, Town or Location **Berlin** 10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number **124 Cedar Ave.** 10f. Zip Code **21811** 10g. Citizen of What Country? **USA**

11. Marital Status ☐ Never Married ☒ Married ☐ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: **white**

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) **7** College (1-4 or 5+) **Farmer** 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Farmer** 16b. Kind of Business/Industry **Grain & Poultry**

17. Father's Name (First, Middle, Last) **Rillie P. Dennis** 18. Mother's Name (First, Middle, Maiden Surname) **Dora A. Smack**

19a. Informant's Name/Relationship (Type, Print) **Barbara Dennis** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **124 Cedar Ave. Berlin, MD 21811**

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) **Dale Cemetery** Date **7/2/97** 20c. Location - City or Town, State **Whaleyville, MD**

21. Signature of Funeral Service Licensee **[Signature]** 22. Name and Address of Facility **Burbage Funeral Home 108 William St. Berlin, MD 21811**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Ischemic Cardiomyopathy** Due to (or as a consequence of): **Coronary Artery Disease** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last { **Peripheral Vascular Disease** Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. **Acute Renal Failure** **Diabetes Mellitus** **Peripheral Vascular Disease** 23b. Did tobacco use contribute to the cause of death? ☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☐ No

25. Was case referred to medical examiner? ☐ Yes ☒ No Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify) 26. Place of Death (Check only one)

27. Manner of Death ☒ Natural ☐ Pending investigation ☐ Accident ☐ Suicide ☐ Homicide ☐ Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury **M** 28c. Injury at Work? ☐ Yes ☐ No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier **[Signature]** 29c. License number **040715** 29d. Date signed (Month, Day, Year) **7/1/97**

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) **STEVEN HEARNE, M.D. 403 QUINCY ST SALISBURY, MD 21801**

31. Date filed (Month, Day, Year) **JUL 01 1997** 32. Registrar's Signature **[Signature]**

State
Registrar

WILLIAM H. DENNIS
217-28-4922
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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 Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

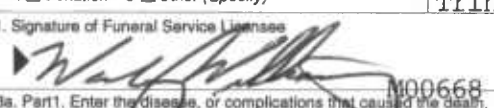


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21009

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carleton Joseph Diedrich Sr.						2. Date of Death Month June Day 30 Year 1997		3. Time of Death 12:45a.m.			
	4a. Facility Name (If not institution, give street and number) 4165 Millburn Place						4b. City, Town, or Location of Death Indian Head		4c. County of Death Charles			
Funeral Director	5. Social Security Number 577-05-4402		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) October 30, 1917		9. Birthplace (State or Foreign Country) Virginia			
	Usual Residence of Decedent						10a. State Maryland		10b. County Charles		10c. City, Town or Location Nanjemoy	
To Be Completed by Funeral Director	10a. Street and Number 9050 Riverside Rd.						10f. Zip Code 20662		10g. Citizen of What Country? U.S.A.		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1942-1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) 12 Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Director of Transportation	
	16b. Kind of Business/Industry U.S. Government						17. Father's Name (First, Middle, Last) Theodore Diedrich		18. Mother's Name (First, Middle, Maiden Surname) Pansy Beach		19a. Informant's Name/Relationship (Type, Print) Carleton Joseph Diedrich, Jr.	
	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5524 Champmans Landing Rd., Indian Head, Md. 20640						20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Trinity Memorial Gardens		20c. Location - City or Town, State Waldorf, Maryland	
	21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Williams Funeral Home, P.A.		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Prostate Cancer		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	23c. Immediate Cause (Final disease or condition resulting in death) Prostate Cancer						23d. Due to (or as a consequence of):		23e. Due to (or as a consequence of):		23f. Due to (or as a consequence of):	
	23g. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						23h. Due to (or as a consequence of):		23i. Due to (or as a consequence of):		23j. Due to (or as a consequence of):	
	23k. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23l. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		23m. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		23n. 25b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined						28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred						28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		28g. 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		
29b. Signature and title of certifier 						29c. License number D28352		29d. Date signed (Month, Day, Year) June 30, 1997		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Krishan Mathur, M.D. - P. O. Box 2729, La Plata, MD 20646		
31. Date filed (Month, Day, Year) JUL 02 1997						32. Registrar's Signature 						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21010

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

REBECCA HATTIE DARGAN

2. Date of Death

JUNE 23, 1997

3. Time of Death

5:45AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

3940 BEXLEY PLACE #716

4b. City, Town, or Location of Death

SUITLAND

4c. County of Death

PRINCE GEORGE'S

5. Social Security Number

250-58-4568

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

AUG. 2, 1930

9. Birthplace (State or Foreign Country)

SUMTER, SC

Usual Residence of Decedent

MARYLAND PRINCE GEORGE'S SUITLAND

10a. State

10b. County

10c. City, Town or Location

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3940 BEXLEY PLACE #716

10f. Zip Code

20746

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3rd

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

HOUSEKEEPER

16b. Kind of Business/Industry

DOMESTIC

17. Father's Name (First, Middle, Last)

BENJAMIN DARGAN

18. Mother's Name (First, Middle, Maiden Surname)

MARTHA MELLOTT

19a. Informant's Name/Relationship (Type, Print)

VIRGINIA BURWELL/ DAUGHTER 5976 ST. MORITZ DR. TEMPLE HILLS, MD

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20748

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

LINCOLN MEMORIAL

Date

6-30-97 SUITLAND, MARYLAND

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Suawara L. Brayton

22. Name and Address of Facility

MARSHALL'S OF MARYLAND

4308 SUITLAND RD. SUITLAND, MD 20746

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)e. Cardiac pulmonary arrest
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. End stage Pancreatic cancer with
liver metastasis stage IV
Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other:

☒ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
Investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ali Al-Attar M.D.

29c. License number

D 50098

29d. Date signed (Month, Day, Year)

6.25.97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ALI AL-ATTAR, M.D. 4900 SILVER HILL RD. SUITLAND, MD 20746

31. Date filed (Month, Day, Year)

JUN 27 1997

32. Registrar's Signature

John A. ...

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

[Faint, mostly illegible text covering the upper and middle portions of the page, possibly bleed-through from the reverse side.]

1000 20 50 80 100 120 140 160 180 200 220 240 260 280 300 320 340 360 380 400 420 440 460 480 500 520 540 560 580 600 620 640 660 680 700 720 740 760 780 800 820 840 860 880 900 920 940 960 980 1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Marjorie Hightower Dennard

2. Date of Death

Month

Day

Year

June

18,

1997

3. Time of Death

11:10 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Doctor's Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

5. Social Security Number

263-07-7448

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Jan. 10, 1919

9. Birthplace (State or Foreign Country)

Florida

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Edmonston

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5122 Decatur Street

10f. Zip Code

20781

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Navar Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerical Worker

16b. Kind of Business/Industry

Department of

Agriculture

17. Father's Name (First, Middle, Last)

William B. Hightower

18. Mother's Name (First, Middle, Maiden Surname)

Annie Elizabeth English

19a. Informant's Name/Relationship (Type, Print)

Dorothy D. Curtis - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7406 Kidmore Court, Lanham, Maryland 20706

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

06/23/97

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

Claudette J. Gasch

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.

4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Cardiopulmonary Arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Acute and Chronic Congestive Heart Failure

Due to (or as a consequence of):

1 Month

c. S/P Mitral Valve Replacement

Due to (or as a consequence of):

9 Years

d. Chronic Obstructive Pulmonary Disease

27 Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

A.D. Moshyedi

29c. License number

D09179

29d. Date signed (Month, Day, Year)

June 23, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Ata Moshyedi, M.D. 7305 Hanover Parkway, Suite A, Greenbelt, Maryland 20770

31. Date filed (Month, Day, Year)

JUN 24 1997

32. Registrar's Signature

John Anderson

State Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Journal of Management Studies, 19(1), 67-80.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 21012

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Evelyn Duffey				2. Date of Death Month Day Year June 21, 1997		3. Time of Death 4:09 pm	
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital				4b. City, Town, or Location of Death Takoma Park		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 217-01-8239		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) June 22, 1915	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Hyattsville	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 5805 42nd Avenue		10f. Zip Code 20781		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		18. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bar Maid / Waitress		16b. Kind of Business/Industry Surf Club			
	17. Father's Name (First, Middle, Last) John Ballard		18. Mother's Name (First, Middle, Maiden Surname) Josephine Ballard		19a. Informant's Name/Relationship (Type, Print) Peggy Williams - Daughter			
Physician /Medical Examiner	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5805 42nd Avenue, Hyattsville, Maryland 20781		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State 06/24/97 Alexandria, Virginia	
	21. Signature of Funeral Service Licensee Claudette S. Gasch		22. Name and Address of Facility Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, Maryland 20781					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebro Vascular Accident Due to (or as a consequence of): b. HYPOTENSION Due to (or as a consequence of): c. COMPLETE HEART BLOCK Due to (or as a consequence of): d.						Approximate Interval Between Onset and Death 4 day 4 day 4 day	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ATRIAL FIBRILLATION						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
Medical Certification: To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29b. Signature and title of certifier V. Singh Attending Phys	
State Registrar	29c. License number 019857		29d. Date signed (Month, Day, Year) 6.21.97		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) V. SINGH 7209 A HANOVER PARKWAY GREENBELT MD 20770			
	31. Date filed (Month, Day, Year) JUN 24, 1997		32. Registrar's Signature Johi Anderson					



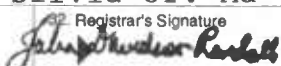
Handwritten text at the top of the page, possibly a title or date.

EVELYN DUFFY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97 21013

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mattie Lola Denny				2. Date of Death Month 6 / Day 23 / Year 97		3. Time of Death 10:20 am		
	4a. Facility Name (If not institution, give street and number) Peninsula Regional Medical Center				4b. City, Town, or Location of Death Salisbury		4c. County of Death Wicomico		
Funeral Director	5. Social Security Number 228-22-2686		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 12-28-20	9. Birthplace (State or Foreign Country) Richmond Va	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Md		10b. County Wicomico		10c. City, Town or Location Salisbury			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number PO Box 84				10f. Zip Code 21679		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4or 5+) 4			18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Domestic		
	17. Father's Name (First, Middle, Last) George Talton Winfrey				18. Mother's Name (First, Middle, Maiden Surname) Lavette Hughes				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Betsy Gallagher				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 320 Centreville Rd Queenstown Md 21679				
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Howard U Med School		Date 6/26/97		20c. Location - City or Town, State Wash DC		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility AAMAN Funeral Service 1601 Kenilworth Ave NE Wash DC 20019				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <div style="display: flex; justify-content: space-between;"><div style="width: 60%;"> Urinary Tract Infection With Sepsis Cerebravascular Accident Myocardial Infarction </div><div style="width: 35%; text-align: right;"> Approximate Interval Between Onset and Death 24 hrs </div></div> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	29b. Signature and title of certifier 				29c. License number D30853		29d. Date signed (Month, Day, Year) 6/23/97		
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles B Silvia Jr. Md PRMC								
	31. Date filed (Month, Day, Year) JUN 26 1997				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21014

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) THOMAS DOLBERRY				2. Date of Death Month Day Year JUNE 24 1997		3. Time of Death 10:40pm	
	4a. Facility Name (If not institution, give street and number) SOUTHERN MARYLAND HOSPITAL				4b. City, Town, or Location of Death CLINTON		4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 578-76-4667		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 41 Yrs.		8. Date of Birth (Month, Day, Year) 04-01-56	
	9. Birthplace (State or Foreign Country) Connecticut		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location District Heights	
To Be Completed by Funeral Director	10e. Street and Number 2100 Addison Road South #2		10f. Zip Code 20747		10g. Citizen of What Country? USA		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	11. Marital Status <input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedant Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4or 5+) 2+		16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cook		16b. Kind of Business/Industry Private			
	17. Father's Name (First, Middle, Last) James Lee Dolberry				18. Mother's Name (First, Middle, Maiden Surname) Mary Ann Hunter			
	19a. Informant's Name/Relationship (Type, Print) Mary Ann Dolberry/Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4304 9th Street, S.E. Washington, DC 20032			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park		20c. Location - City or Town, State Landover, Maryland		20d. Date 6/30/97	
	21. Signature of Funeral Service Licensee Nancy A. Perantoni				22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Road, Landover, Maryland			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SEPSIS Due to (or as a consequence of): ACQUIRED IMMUNE DEFICIENCY SYNDROME Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b are marked other than "natural", or items 23a or 23b are marked other than "natural", the Medical Examiner must be notified at once.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ANAEMIA ABNORMAL LIVER FUNCTION TEST							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how Injury occurred					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Legen chend lina				29c. License number D0050653		29d. Date signed (Month, Day, Year) 6/24/97		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 7501 SURRATTS ROAD CLINTON MD SURANA								
31. Date filed (Month, Day, Year) JUN 26 1997				32. Registrar's Signature John Hunter Rusk				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

21015

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ralph B. Echols				2. Date of Death Month Day Year June 23, 1997		3. Time of Death 6:55 PM	
	4e. Facility Name (If not Institution, give street and number) Atlantic General Hospital				4b. City, Town, or Location of Death Berlin		4c. County of Death Worcester	
Funeral Director	5. Social Security Number 578 56 4613	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F XX	7. Age (In yrs. last birthday) 55 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec 15, 1941		9. Birthplace (State or Foreign Country) Washington DC
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland		10b. County Worcester		10c. City, Town or Location Berlin		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number #39 Cresthaven Drive				10f. Zip Code 21811		10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) System Analyst		16b. Kind of Business/Industry Federal Government	
	17. Father's Name (First, Middle, Last) George Echols				18. Mother's Name (First, Middle, Maiden Surname) Dorothy Sweeney			
	19a. Informant's Name/Relationship (Type, Print) Pamela B. Echols				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 Bluff Terrace, Silver Spring, MD 20902			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		20c. Location - City or Town, State Suitland, Maryland		20d. Date of Disposition June 27, 1997	
	21. Signature of Funeral Service Licensee Charles L. Belanger				22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Rd, Clinton, Md 20735			
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. pneumonia and sepsis Due to (or as a consequence of): b. COPD Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death hours to 1 day years							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. medically examined with my assessment no need for Autopsy							
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Ben C. Belanger		29c. License number D47676		29d. Date signed (Month, Day, Year) 6/23/97
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B. Touleimat, MD 9733 Health Way Drive, Berlin, Md 21811								
31. Date filed (Month, Day, Year) JUL 02 1997				32. Registrar's Signature John Davidson-Randall				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DAVID FINCHAM JR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21016

ASP Items: 23a part I, 27, 28a-f per ME0 G-749 7/14/97 dh Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DAVID F. FINCHAM, JR.			2. Date of Death Month Day Year JUNE 30 1997		3. Time of Death 12:27 A														
	4a. Facility Name (If not institution, give street and number) 5112 BELAIR RD.			4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE														
Funeral Director	5. Social Security Number 214-66-6631		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 41 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) SEPT. 25, 1955													
	9. Birthplace (State or Foreign Country) MARYLAND																			
Usual Residence of Decedent																				
10a. State MD		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No														
10e. Street and Number 5112 BELAIR RD.				10f. Zip Code 21206		10g. Citizen of What Country? USA														
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE														
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TAXI CAB DRIVER		16b. Kind of Business/Industry TRANSPORTATION														
17. Father's Name (First, Middle, Last) DAVID F. FINCHAM, SR.				18. Mother's Name (First, Middle, Maiden Surname) IRENE A. MORRIS																
19a. Informant's Name/Relationship (Type, Print) IRENE A. MORRIS (MOTHER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MC 25 TALL PINES, LEWES, DE 19958																
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) SILVERBROOK CEM.		Date 7/7/97		20c. Location - City or Town, State WILMINGTON, DE														
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility HICKS HOME FOR FUNERALS BOW & STOCKTON STS., ELKTON, MD 21921																
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																				
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>NARCOTIC (MEPERIDINE) INTOXICATION</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	NARCOTIC (MEPERIDINE) INTOXICATION	Due to (or as a consequence of):	b.		Due to (or as a consequence of):	c.		Due to (or as a consequence of):	d.		Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	NARCOTIC (MEPERIDINE) INTOXICATION	Due to (or as a consequence of):																	
	b.		Due to (or as a consequence of):																	
	c.		Due to (or as a consequence of):																	
	d.		Due to (or as a consequence of):																	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown														
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No														
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No														
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																		
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) found: 6/30/97		28b. Time of Injury unknown M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) found in house		28d. Describe how injury occurred unknown																
				28f. Location (Street and Number or Rural Route Number, City or Town, State) 5112 Belair Rd., Baltimore, MD.																
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier 																		
		29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) JUNE 30, 1997																
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Stephen S. Radentz, MD 111 Penn Street, Baltimore, Maryland 21201																				
31. Date filed (Month, Day, Year) JUL 10 1997		32. Registrar's Signature 																		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Page 100

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State of Maryland / Department of Health and Mental Hygiene

97 21017

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Roger B Fuson

2. Date of Death

June 19, 1997

3. Time of Death

6:01

Funeral
Director

4e. Facility Name (If not institution, give street and number)

Calvert Memorial Hospital

4b. City, Town, or Location of Death

Prince Frederick

4c. County of Death

Calvert

5. Social Security Number

405 10 2452

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 7, 1916

9. Birthplace (State or Foreign Country)

Kentucky

Usual Residence of Decedent

10a. State
Maryland Calvert

10b. County

10c. City, Town or Location

Port Republic

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2 Azalea Road

10f. Zip Code

20676

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Scientist

16b. Kind of Business/Industry

Research/ NIH

17. Father's Name (First, Middle, Last)

Charles Livingston Fuson

18. Mother's Name (First, Middle, Maiden Surname)

Clyda Baker

19a. Informant's Name/Relationship (Type, Print)

Lucille A. Fuson-wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2 Azalea Rd. Port Republic, Maryland 20676

20e. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

June 20 1997

20c. Location - City or Town, State

Alexandria Virginia

21. Signature of Funeral Service Licensee

B. Rausch

22. Name and Address of Facility

Rausch Funeral Home

4405 Broomes Is. Rd. Port Republic MD 20676

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. *Cardiomyopathy - non ischemic*
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mark Kushner MD

29c. License number

D23468

29d. Date signed (Month, Day, Year)

6/19/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark Kushner

31. Date filed (Month, Day, Year)

JUN 23 1997

32. Registrar's Signature

John Anderson-Russell

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21018

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edward William Fitzwater				2. Date of Death Month Day Year June 16, 1997		3. Time of Death 1635				
	4a. Facility Name (If not institution, give street and number) 48333 Driftwood Court, Apt. 200 B				4b. City, Town, or Location of Death Lexington Park		4c. County of Death St. Mary's				
Funeral Director	5. Social Security Number 214-01-7658		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) November 23, 1922		9. Birthplace (State or Foreign Country) Virginia		
	10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Lexington Park		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
10e. Street and Number 48333 Driftwood Court, Apt. 200 B		10f. Zip Code 20653		10g. Citizen of What Country? United States							
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Ticket Agent		16b. Kind of Business/Industry Railroad							
17. Father's Name (First, Middle, Last) Victor Fitzwater				18. Mother's Name (First, Middle, Maiden Surname) Ina Mae Rhodes							
19a. Informant's Name/Relationship (Type, Print) Richard A. Fitzwater, Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 48165 Mayflower Drive, Lexington Park, MD 20653							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans' Cemetery		Date 6/20/97		20c. Location - City or Town, State Cheltenham, Maryland					
21. Signature of Funeral Service Director Michael K. Blankenship		22. Name and Address of Facility Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Probable Myocardial Infarction Sec. Dua to (or as a consequence of): b. Dua to (or as a consequence of): c. Dua to (or as a consequence of): d. Dua to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. - CVA - Hypertension								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier William Boyd II, M.D.		29c. License number A14285		29d. Date signed (Month, Day, Year) 6-17-97					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Boyd II, M.D. Leonardtown, Maryland 20650											
31. Date filed (Month, Day, Year) JUN 19 1997		32. Registrar's Signature John Davidson-Kendall									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21019

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Jackson Freeman				2. Date of Death Month May Day 31 Year 1997		3. Time of Death 9:57 PM											
	4a. Facility Name (If not institution, give street and number) 317 Norris Road				4b. City, Town, or Location of Death Great Mills		4c. County of Death St. Mary's											
Funeral Director	5. Social Security Number 217-42-2285		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 51 Yrs.		8. Date of Birth (Month, Day, Year) December 21, 1945											
	9. Birthplace (State or Foreign Country) Virginia																	
Usual Residence of Decedent																		
10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Great Mills			10d. Inside City Limits 1 Yes 2 No											
10e. Street and Number 317 Norris Road				10f. Zip Code 20634		10g. Citizen of What Country? United States												
11. Marital Status 1 Navar Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:			14. Race - American Indian, Black, White, etc. Specify: White											
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanic			16b. Kind of Business/Industry Automobile											
17. Father's Name (First, Middle, Last) Leonard Freeman				18. Mother's Name (First, Middle, Maiden Surname) Venus Moore														
19a. Informant's Name/Relationship (Type, Print) Jackleen Freeman Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 317 Norris Road, Great Mills, Maryland 20634														
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date 6/3/97		20c. Location - City or Town, State Alexandria, Virginia												
21. Signature of Funeral Service Licensee Edward N. Brinsfield, Jr. M00052				22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650														
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																		
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Carcinomatosis</td> <td rowspan="4"> Approximate Interval Between Onset and Death 6 mo. 1 yr. </td> </tr> <tr> <td>b.</td> <td>Carcinoma of larynx</td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	Carcinomatosis	Approximate Interval Between Onset and Death 6 mo. 1 yr.	b.	Carcinoma of larynx	c.		d.	
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	Carcinomatosis	Approximate Interval Between Onset and Death 6 mo. 1 yr.															
	b.	Carcinoma of larynx																
	c.																	
	d.																	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown												
						24a. Was an autopsy performed? 1 Yes 2 No												
						24b. Were autopsy findings available prior to completion of cause of death? N/A												
25. Was case referred to medical examiner? 1 Yes 2 No				26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)														
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred										
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)														
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																		
29b. Signature and title of certifier James P. Jarboe, M.D.				29c. License number D 06419		29d. Date signed (Month, Day, Year) 6-2-97												
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) James P. Jarboe, M.D. Leonardtown, Maryland 20650																		
31. Date filed (Month, Day, Year) JUN 03 1997				32. Registrar's Signature John Davidson Randall														

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21020

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gordon Theodore Fedders				2. Date of Death Month Day Year June 1, 1997		3. Time of Death 5:30 PM	
	4e. Facility Name (If not institution, give street and number) Charlotte Hall Veterans Home				4b. City, Town, or Location of Death Charlotte Hall		4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 074-12-9583		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 79		8. Date of Birth (Month, Day, Year) Jun 27, 1917	
	9. Birthplace (State or Foreign Country) New York		10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Dameron	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 16690 St. Jeromes Neck Road		10f. Zip Code 20628		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 3 years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electronic Engineer		16b. Kind of Business/Industry U.S. Government			
	17. Father's Name (First, Middle, Last) Theodore C. Fedders, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Ethel Luella Amos			
	19a. Informant's Name/Relationship (Type, Print) Mark W. Fedders/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1121 John Sharp Rd., Spring Hill, TN 37174			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MD Veterans Cemetery		Date 6/5/97		20c. Location - City or Town, State Cheltenham, MD	
	21. Signature of Funeral Service Licensee <i>Michael L. Gardiner</i>				22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>CONGESTIVE HEART FAILURE</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>HEMOCHROMATOSIS</i> <i>Myelo DYSPLASIA</i>							
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined							
Medical Certification: To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day Year)							
	28b. Time of Injury M							
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
	28d. Describe how injury occurred							
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>John A. Waldorf</i> ATTENDING								
29c. License number D-44436								
29d. Date signed (Month, Day, Year) JUNE 02 1997								
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>ASHVIN KUMAR J PATEL, MD</i> 603 POST OFFICE RD WALDORF MD 20602								
State Registrar	31. Date filed (Month, Day, Year) JUN 04 1997				32. Registrar's Signature <i>John Davidson Randall</i>			

Gordon T. Fedders 06/01/97 5:30pm

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1241

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that this is essential for ensuring the integrity of the financial system and for providing a clear audit trail.

2. The second part of the document outlines the various methods used to collect and analyze data. It describes how data is gathered from different sources and how it is then processed to identify trends and patterns.

3. The third part of the document focuses on the results of the analysis. It presents a series of charts and graphs that illustrate the findings of the study. These results show a clear correlation between the variables being studied.

4. The fourth part of the document discusses the implications of the findings. It suggests that the results of the study have significant implications for the way in which the financial system is managed and operated.

5. The fifth part of the document provides a summary of the key points discussed in the document. It reiterates the importance of accurate record-keeping and the need for thorough data analysis.

6. The sixth part of the document contains a list of references to the sources used in the study. These references include books, articles, and other documents that provide additional information on the topics discussed in the document.

7. The seventh part of the document is a conclusion. It summarizes the main findings of the study and provides a final statement on the importance of the research.

8. The eighth part of the document is a list of appendices. These appendices contain additional information that is related to the study but is not included in the main body of the document.

9. The ninth part of the document is a list of footnotes. These footnotes provide additional information on specific points mentioned in the document.

10. The tenth part of the document is a list of index. This index provides a quick reference to the various sections of the document.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21021

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EULALIA FULBRIGHT

2. Date of Death

Month

Day

Year

6

13

97

3. Time of Death

10:15p.m.

4a. Facility Name (If not institution, give street and number)

Mariner Nursing Home

4b. City, Town, or Location of Death

Clinton

4c. County of Death

P.G.

Funeral
Director

5. Social Security Number

457-36-2274

6. Sex

1 ☐ M2 ☒ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

8/2/1909

9. Birthplace (State or Foreign Country)

Texas

Usual Residence of Decedent

10a. State

MD

10b. County

P.G.

10c. City, Town or Location

Clinton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9211 Stuart Lane

10f. Zip Code

20735

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married2 ☐ Married3 ☒ Widowed4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housekeeper

16b. Kind of Business/Industry

private

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

Leanna Bailey

19a. Informant's Name/Relationship (Type, Print)

Patsy Woods

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13104 Burleigh St. Kettering, Md. 20774

20a. Method of Disposition

1 ☒ Burial2 ☐ Cremation3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ft. Lincoln Cemetery

Date

6/19/97

20c. Location - City or Town, State

Brentwood, Md.

21. Signature of Funeral Service Licensee

Price Edwards

22. Name and Address of Facility

Hodges and Edwards

3910 Silver Hill RD. Suitland, Md.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. HYPERTENSIVE HEART DISEASE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 x 4 YRS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Price Edwards

29c. License number

20391

29d. Date signed (Month, Day, Year)

JUN 24, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR JEFFREY KELMAN 6525 BELCREST ROAD, HYATTSVILLE, MD

31. Date filed (Month, Day, Year)

JUN 26 1997

32. Registrar's Signature

John D. Anderson

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21022

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edward Joseph Ford, Jr.

2. Date of Death

Month Day Year
JUNE 24, 1997

3. Time of Death

8:25 am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

213-32-8395

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

61 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
5/6/36

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2102 Coralhorn Rd.

10f. Zip Code

21220

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 10/53 to 10/55

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Mailer

16b. Kind of Business/Industry

Baltimore Sun Paper

17. Father's Name (First, Middle, Last)

Edward Joseph Ford, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Norma M. Gittings

19a. Informant's Name/Relationship (Type, Print)

Faith R. Ford / Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2102 Coralhorn Rd., Baltimore, MD 21220

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Trenton Cemetery

Date

6/26/97 Upperco, MD 21155

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Steven W. [Signature]

22. Name and Address of Facility

Eline Funeral Home, 934 S. Main St
Hampstead, MD 21074

23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. SEPSIS

Due to (or as a consequence of):

b. CIRRHOSIS

Due to (or as a consequence of):

c. HEPATITIS B

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

3 d

5 y

~10 y

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

David R. Kafonek M.D.

29c. License number

D31011

29d. Date signed (Month, Day, Year)

6/24/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUITE 301

10751

FALLS RD

TIMONIUM MD.

31. Date filed (Month, Day, Year)

JUN 26 1997

32. Registrar's Signature

[Signature]

State
Registrar

EDWARD FORD, JR.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21023

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Aurella Freeman

2. Date of Death

Month
JUNEDay
30Year
1997

3. Time of Death

8:30 P:M

4e. Facility Name (If not institution, give street and number)

PHYSICIANS MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

LAPLATA

4c. County of Death

CHARLES

Funeral
Director

5. Social Security Number

216-88-3562

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 4, 1922 Virginia

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

Maryland Charles

10b. County

10c. City, Town or Location

Nanjemoy

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8780 Riverside Rd.

10f. Zip Code

20662

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Her Home

17. Father's Name (First, Middle, Last)

Henry Minnix

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Lorene Freeman

Daughter

Same as #10

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Nanjemoy Baptist Church

Date

July 3, 1997

20c. Location - City or Town, State

Nanjemoy, Maryland

21. Signature of Funeral Service Licensee

M00668

22. Name and Address of Facility

Williams Funeral Home, P.A.

4270 Hawthorne Rd. Indian Head, Md. 20640

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Cardiopulmonary Arrest

Approximate
Interval Between
Onset and Death
~ 6:30pm 6/20/97

Due to (or as a consequence of):

b. Congestive Heart Disease

Years

Due to (or as a consequence of):

c. Hypertensive Cardiomyopathy

Years

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural
2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide5 ☐ Pending
investigation
6 ☐ Could not be
determined

28a. Date of Injury

(Month, Day, Year)
6/30/9728b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and Title of Certifier

29c. License number

D46979

29d. Date signed (Month, Day, Year)

7/1/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr Collins Pein

MD, 11345 PENARCOKE SQUARE, SUITE 104
WASHOORE, MD. 20603

31. Date filed (Month, Day, Year)

JUL 02 1997

32. Registrar's Signature

Julia Anderson-Randall

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

AURELIA FREEMAN

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21024

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BETTY FRECHETTE						2. Date of Death Month Day Year JUNE 24, 1997		3. Time of Death 12:32 P.M.						
	4a. Facility Name (If not institution, give street and number) MALCOLM GROW MEDICAL CENTER						4b. City, Town, or Location of Death CAMP SPRINGS		4c. County of Death PRINCE GEORGE'S						
Funeral Director	5. Social Security Number 508-48-5783		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 60 Yrs.		8. Date of Birth (Month, Day, Year) Jan 16, 1937		9. Birthplace (State or Foreign Country) England						
	Usual Residence of Decedent 10a. State Maryland 10b. County Charles 10c. City, Town or Location Waldorf 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 10e. Street and Number 3207 Pinefield Circle 10f. Zip Code 20601 10g. Citizen of What Country? United States														
To Be Completed by Funeral Director	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Instruction Asst.				16b. Kind of Business/Industry Charles County Board of Education								
	17. Father's Name (First, Middle, Last) Arthur Goodge						18. Mother's Name (First, Middle, Maiden Surname) Margaret Robinson								
	19a. Informant's Name/Relationship (Type, Print) Robert A. Frechette						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3207 Pinefield Circle, Waldorf, Md 20601								
Physician /Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) June 30, 1997 Maryland Veterans Cemetery				20c. Location - City or Town, State Cheltenham, Maryland								
	21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd, Clinton, Md								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE HEMORRHAGE OF ARACHNOID SPACE AND PARIETAL LOBE Due to (or as a consequence of): b. METASTATIC ADENOCARCINOMA OF THE BRAIN Due to (or as a consequence of): c. METASTATIC ADENOCARCINOMA, UNKNOWN PRIMARY Due to (or as a consequence of): d. UNKNOWN CARCINOGEN										Approximate Interval Between Onset and Death 1 DAY 2 WEEKS UNKNOWN UNKNOWN				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MULTIPLE LIVER METASTATIC LESIONS MULTIPLE PLEURAL LESIONS BELIEVED TO BE METASTATIC NEOPLASMS										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)												
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred						
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. Signature and title of certifier 		29c. License number MD D48119		29d. Date signed (Month, Day, Year) JUNE 24, 1997
State Registrar	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) RICHARD BRANSDORF, MAJ, USAF, MC						30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ANDREWS AIR FORCE BASE, MD 20762-6600								
	31. Date filed (Month, Day, Year) JUL 02 1997						32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit certificate.

JAMES Item:5 per FH G-749 7/16/97 dh

State of Maryland / Department of Health and Mental Hygiene

GASS Items:23a part I,27,28a-f per ME0 G-749 7/14/97 dh

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

JAMES MICHAEL GASS

2. Date of Death

Month Day Year
JUNE 28 1997

3. Time of Death

10:30 P.M.

4a. Facility Name (If not institution, give street and number)

143 FAIRVIEW AVE

4b. City, Town, or Location of Death

KINGSTOWN

4c. County of Death

QUEEN ANNES

5. Social Security Number

778-40-2765

6. Sex

M 2 ☐ F

7. Age (In yrs. last birthday)

47 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 24, 1949

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Md.

10b. County

Queen Anne's

10c. City, Town or Location

Kingstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

143 Fairview Ave.

10f. Zip Code

21620

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

5

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Pharmacist

16b. Kind of Business/Industry

Medical-Pharmacy

17. Father's Name (First, Middle, Last)

George Gass

18. Mother's Name (First, Middle, Maiden Surname)

Helen Hilary

19a. Informant's Name/Relationship (Type, Print)

Barbara Gass (Ex-Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

723 Kimberly Way, Stevensville, Md. 21666

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Chesapeake Cremation Center Stevensville, Md.

Date

July 2, 1997

20c. Location - City or Town, State

Stevensville, Md.

21. Signature of Funeral Service Licensee

Thomas K. Helfenbein

22. Name and Address of Facility

Fellows, Helfenbein &
Newnam Funeral Home, P.A.
106 Shamrock Rd., Chester, Md. 21619

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PHENOBARBITAL INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☒ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

found: 6/28/97

28b. Time of Injury

found 10:30

28c. Injury at Work?

1 ☐ Yes 2 ☒ No28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
home

28d. Describe how injury occurred

subject ingested drug

28f. Location (Street and Number or Rural Route Number, City or Town, State) 143 Fairview Ave.,
Kingstown, Md.

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Donald G. Wright MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JUNE 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DONALD G. WRIGHT MD

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUL 10 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21026

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY MADELINE GOLDRING

2. Date of Death

Month Day Year
June 28 1997

3. Time of Death

12:19 PM

4a. Facility Name (If not institution, give street and number)

PHYSICIANS MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

LAPLATA

4c. County of Death

CHARLES

Funeral
Director

5. Social Security Number

218-26-5719

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
OCT 5 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Waldorf

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3012-A Palmer Place

10f. Zip Code

20602

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
3

College (1-4 or 5+)

16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Robert P. Butler

18. Mother's Name (First, Middle, Maiden Surname)

Ella R. Shade Butler

19a. Informant's Name/Relationship (Type, Print)

Mary T. Morman (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4922 Megan Drive Clinton, MD 20735

20a. Method of Disposition

X ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

St Mary's Church Cem.

Date

7-3-97

20c. Location - City or Town, State

Bryantown, MD

21. Signature of Funeral Service Licensee

M00173

22. Name and Address of Facility

J.H. Eberwein Mortuary

4433 White Pls 1a White Pls, MD 20695

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e. Cardiac arrest

Due to (or as a consequence of):

b. Aortic stenosis and Aortic Incompetence

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28e. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Girija Rath MD CENNA MEDICAL CENTER

29c. License number

D-12587

29d. Date signed (Month, Day, Year)

6-29-1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

GIRIJA RATH MD CENNA MEDICAL CENTER 7-C POST OFFICE RD WALDORF, MD 20602

31. Date filed (Month, Day, Year)

JUL 01 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

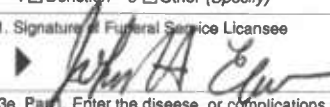

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97 21027

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mattie Helen Gushee					2. Date of Death Month June Day 29 Year 1997		3. Time of Death 2:45p.m.	
	4a. Facility Name (If not institution, give street and number) 7820 Tall Oaks Place					4b. City, Town, or Location of Death Charlotte Hall		4c. County of Death Charles	
Funeral Director	5. Social Security Number 254-38-3335		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) NOV 14 1924		9. Birthplace (State or Foreign Country) Georgia
	Usual Residence of Decedent								
10a. State Maryland			10b. County Charles		10c. City, Town or Location Charlotte Hall			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 7820 Tall Oaks Place					10f. Zip Code 20622		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 College (1-4 or 5+) 1					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) Leonidas L. Frierson					18. Mother's Name (First, Middle, Maiden Surname) Mattie E. Tarver Frierson				
19a. Informant's Name/Relationship (Type, Print) A. Chester Gushee (Husband)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7820 Tall Oaks Place Charlotte Hall, MD 20622				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Pisgah United Meth. Cem.		Date 7-2-96		20c. Location - City or Town, State Pisgah, MD 20640		
21. Signature of Funeral Service Licensee  M00173					22. Name and Address of Facility J.H. Eberwein Mortuary 4433 White Pls La White Pls., MD 20695				
23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Chronic Heart Failure and Kidney Failure									Approximate Interval Between Onset and Death
23b. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier  Krishan Mathur, M.D.					29c. License number D28352		29d. Date signed (Month, Day, Year) June 30, 1997		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Krishan Mathur, M.D. - P. O. Box 2729, La Plata, MD 20646									
31. Date filed (Month, Day, Year) JUL 01 1997			32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21028

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EDNA REBECCA GRAVES						2. Date of Death Month: June Day: 17 Year: 1997		3. Time of Death 7:01AM	
	4a. Facility Name (If not institution, give street and number) St. Mary's Hospital						4b. City, Town, or Location of Death Leonardtown		4c. County of Death St. Mary	
Funeral Director	5. Social Security Number 219-14-0695		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) March 3, 1925		9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10e. State MD		10b. County St. Mary		10c. City, Town or Location Mechanicville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 9655 North Ryceville Rd				10f. Zip Code 20659		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 Collega (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) William Turner Mays						18. Mother's Name (First, Middle, Maiden Surname) Amy Theresa Turner			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Glenn Irving Graves/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9655 North Ryceville Rd., Mechanicville, MD 20659					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Mary's Catholic Cem		20c. Location - City or Town, State 6/20/97 Bryantown, MD					
	21. Signature of Funeral Service Licensee Michael F. Gardiner				22. Name and Address of Facility Matteringley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Sepsis Due to (or as a consequence of): b. Pneumonia Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 48 hrs. 6-7 days									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. LEFT HIP FRACTURE RIGHT LEG ARTERIAL INSUFFICIENCY									
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 6/8/97		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred Fell at home	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Mark Henderson		29c. License number 040288		29d. Date signed (Month, Day, Year) 6/19/97			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Mark Henderson, M.D. 600 Moakley St. Leonardtown, MD 20650									
	31. Date filed (Month, Day, Year) JUN 19 1997		32. Registrar's Signature Julia Davidson-Randall							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21029

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHARLES JOHNSON GILL, JR.				2. Date of Death Month Day Year June 21, 1997		3. Time of Death 4:50 A.M.	
	4a. Facility Name (If not institution, give street and number) GOLDEN OAKS CONVALESCENT REHABILITATION Ctr.				4b. City, Town, or Location of Death Laurel		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 577-44-9516		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 60 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 6, 1936	
	9. Birthplace (State or Foreign Country) Washington, D.C.		10a. State District of Columbia		10b. County Washington		10c. City, Town or Location Washington	
To Be Completed by Funeral Director	10d. Inside City Limits 1 Yes 2 No		10e. Street and Number 5119 Sheriff Road, N. E.		10f. Zip Code 20019		10g. Citizen of What Country? United States	
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 Yes 2 No		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver		16b. Kind of Business/Industry Private - PEPCO		17. Father's Name (First, Middle, Last) Charles Johnson Gill, Sr.	
	18. Mother's Name (First, Middle, Maiden Surname) Aver W. Hunter		19a. Informant's Name/Relationship (Type, Print) Sylvia J. Gill - Sister		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5046 Sheriff Road, N.E., Washington, D.C. 20019		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	
Physician /Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland National Memorial Park		20c. Date 6/25/97		20d. Location - City or Town, State Laurel, MD		21. Signature of Funeral Service Licensee John T. Stewart III	
	22. Name and Address of Facility STEWART FUNERAL HOME, INC. 4001 Benning Road, N.E., Washington, D. C. 20019		23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Lung Cancer		23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown		23c. Was an autopsy performed? 1 Yes 2 No	
Medical Certification: To Be Completed by Physician/Medical Examiner	24a. Immediate Cause (Final disease or condition resulting in death) Lung Cancer		24b. Due to (or as a consequence of): Months		24c. Due to (or as a consequence of):		24d. Due to (or as a consequence of):	
	24e. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dehydration		24f. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24g. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No		24h. Describe how injury occurred	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)		27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		28a. Date of Injury (Month, Day Year)	
	28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
State Registrar	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Jenny Y May MD		29c. License number D43260		29d. Date signed (Month, Day, Year) June 24, 1997	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jenny Y May MD 14333 Laurel Bowie Rd #307 Laurel MD 20708		31. Date filed (Month, Day, Year) JUN 27 1997		32. Registrar's Signature John Andrew Randall			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21030

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Delores Jean Groomes				2. Date of Death Month Day Year June 19, 1997		3. Time of Death 6:25p.m.	
	4e. Facility Name (If not institution, give street and number) Doctor's Community Hospital				4b. City, Town, or Location of Death Lanham		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 577-40-6914		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 64 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 1, 1932	
	9. Birthplace (State or Foreign Country) Washington, DC		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Riverdale	
Usual Residence of Decedent								
10a. State Maryland			10b. County Prince George's			10c. City, Town or Location Riverdale		
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			10e. Street and Number 4917 Nicholson Street			10f. Zip Code 20737		
10g. Citizen of What Country? U.S.A.			11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+)		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife			16b. Kind of Business/Industry Own Home			17. Father's Name (First, Middle, Last) Wallace W. Cook		
18. Mother's Name (First, Middle, Maiden Surname) Fannie Stables			19e. Informant's Name/Relationship (Type, Print) Jacob Groomes, Sr. - Husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4917 Nicholson Street, Riverdale, Maryland 20737		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery			20c. Location - City or Town, State 06/23/97 Brentwood, Maryland		
21. Signature of Funeral Service Licensee Claudette S. Gasch			22. Name and Address of Facility Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781					
23a. Per 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Staph Aureus Sepsis Due to (or as a consequence of): b. Bacterial Endocarditis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Approximate Interval Between Onset and Death 1 week								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)			28b. Time of Injury M		
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)			29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier Dr. Delores Siph MD			29c. License number D 45660			29d. Date signed (Month, Day, Year) 6-20-97		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3060, Mitchellville Rd, Bowie MD 20716								
31. Date filed (Month, Day, Year) JUN 23 1997			32. Registrar's Signature John Andrew Raskel					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21031

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Theresa A. Garnavich				2. Date of Death June 18, 1997		3. Time of Death 9:40 P.M.												
	4a. Facility Name (If not institution, give street and number) 14209 Masterpiece Lane				4b. City, Town, or Location of Death Potomac		4c. County of Death Montgomery												
Funeral Director	5. Social Security Number 379 16 7001	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 21, 1919		9. Birthplace (State or Foreign Country) Michigan											
	Usual Residence of Decedent																		
To Be Completed by Funeral Director	10a. State Maryland	10b. County Montgomery	10c. City, Town or Location Potomac			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No													
	10e. Street and Number 14209 Masterpiece Lane			10f. Zip Code 20878		10g. Citizen of What Country? United States													
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White												
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Registered Nurse		16b. Kind of Business/Industry Hospital														
	17. Father's Name (First, Middle, Last) Antonio Battuello			18. Mother's Name (First, Middle, Maiden Surname) Caroline Demarie															
	19a. Informant's Name/Relationship (Type, Print) Patricia A. Sylvia Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14209 Masterpiece Lane Potomac Maryland 20878															
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lakeview Cemetery 6/23/97		Date 6/23/97		20c. Location - City or Town, State Calumet Michigan												
	21. Signature of Funeral Service Licensee <i>Michael L. Bigler</i>			22. Name and Address of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715															
	23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																		
	<table border="0"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>e. LIVER METASTASIS</td> <td>Approximate Interval Between Onset and Death 6 MONTHS</td> </tr> <tr> <td rowspan="4">Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. ADENOCARCINOMA OF UNKNOWN PRIMARY</td> <td>1 YEAR</td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> <tr> <td></td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	e. LIVER METASTASIS	Approximate Interval Between Onset and Death 6 MONTHS	Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. ADENOCARCINOMA OF UNKNOWN PRIMARY	1 YEAR	c.		d.		
Immediate Cause (Final disease or condition resulting in death)	e. LIVER METASTASIS	Approximate Interval Between Onset and Death 6 MONTHS																	
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. ADENOCARCINOMA OF UNKNOWN PRIMARY	1 YEAR																	
	c.																		
	d.																		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown													
						24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No													
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No													
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No													
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred															
		28f. Location (Street and Number or Rural Route Number, City or Town, State)																	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																			
29b. Signature and title of certifier <i>James E. Butrynski M.D.</i>		29c. License number MARYLAND D50308		29d. Date signed (Month, Day, Year) JUNE 18, 1997															
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAMES E. BUTRYNSKI, NNMC, 8901 WISCONSIN AVE, BLDG 2, Rm 5101 BETHESDA, MD 20884																			
31. Date filed (Month, Day, Year) JUN 24, 1997		32. Registrar's Signature <i>John Andrew Randall</i>																	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

WILSON

WILSON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97 21032

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret Louise Garrison					2. Date of Death Month June Day 23 Year 1997		3. Time of Death 2:00 a.m.	
	4e. Facility Name (If not institution, give street and number) 7415 Allison Street					4b. City, Town, or Location of Death Landover Hills		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 217-14-6742	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months 0 Days 0	If Under 24 Hrs. Hours 0 Min. 0	8. Date of Birth (Month, Day, Year) March 17, 1921		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland	10b. County Prince George's	10c. City, Town or Location Landover Hills			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number 7415 Allison Street			10f. Zip Code 20784		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Switchboard Operator		16b. Kind of Business/Industry DC Transit Company				
	17. Father's Name (First, Middle, Last) Richard Anderson					18. Mother's Name (First, Middle, Maiden Surname) Carrie R. Shaw			
	19a. Informant's Name/Relationship (Type, Print) Margaret L. Royer - Daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7415 Allison Street, Landover Hills, Maryland 20784			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		Date 06/25/97	20c. Location - City or Town, State Brentwood, Maryland			
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
	<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </div> <div style="width: 60%;"> a. Cerebrovascular Accident Due to (or as a consequence of): b. Atrial Fibrillation Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ </div> <div style="width: 10%; text-align: center;"> Approximate Interval Between Onset and Death Immediate years. </div> </div>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 				29c. License number 040216		29d. Date signed (Month, Day, Year) 6/24/97			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dennis A. Cullen, M.D. 4333 Old Branch Avenue, Marlow Heights, Maryland 20748									
31. Date filed (Month, Day, Year) JUN 25 1997		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

1992

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97 21033

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>MILDRED GROSE</i>					2. Date of Death Month <i>6</i> Day <i>22</i> Year <i>97</i>			3. Time of Death <i>1:25 AM</i>		
	4a. Facility Name (If not institution, give street and number) <i>Snow Hill Nursing & Rehab Center</i>					4b. City, Town, or Location of Death <i>SNOW HILL</i>			4c. County of Death <i>WORCESTER</i>		
Funeral Director	5. Social Security Number <i>579-18-6267</i>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>92</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>April 20, 1905</i>		9. Birthplace (State or Foreign Country) <i>Maryland</i>		
	Usual Residence of Decedent										
10a. State <i>Maryland</i>		10b. County <i>Prince George's</i>		10c. City, Town or Location <i>Hyattsville</i>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number <i>5608 Newton Street</i>					10f. Zip Code <i>20784</i>			10g. Citizen of What Country? <i>U.S.A.</i>			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>White</i>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>2</i> College (1-4 or 5+) <i>2</i>					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Teacher & Businesswoman</i>			16b. Kind of Business/Industry <i>National Security Agency</i>			
17. Father's Name (First, Middle, Last) <i>John Selby Holston</i>					18. Mother's Name (First, Middle, Maiden Surname) <i>Sally Clark Holston</i>						
19a. Informant's Name/Relationship (Type, Print) <i>Sam Keiffer - Son</i>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>8930 Harmony Court, Owings, Maryland 20736</i>						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Fort Lincoln Cemetery</i>			Date <i>06/26/97</i>		20c. Location - City or Town, State <i>Brentwood, Maryland</i>			
21. Signature of Funeral Service Licensee <i>H. Constance Gasch</i>					22. Name and Address of Facility <i>Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781</i>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. ESSENTIAL HYPERTENSION</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <i>b. Due to (or as a consequence of):</i> <i>c. Due to (or as a consequence of):</i> <i>d. Due to (or as a consequence of):</i>										Approximate Interval Between Onset and Death <i>75 YEARS</i>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>ALZHEIMER'S DISEASE, SP HERPES</i> <i>ZOSTER</i>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <i>Dorothy C. Holzworth, M.D.</i>					29c. License number <i>D 06241</i>			29d. Date signed (Month, Day, Year) <i>6-22-97</i>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>DOROTHY C. HOLZWORTH, M.D. 203 SNOW ST., SNOW HILL, MD. 21863</i>											
31. Date filed (Month, Day, Year) <i>JUN 25 1997</i>					32. Registrar's Signature <i>John Davidson-Rodell</i>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

STATE OF TEXAS, COUNTY OF DALLAS, ss. I, the undersigned, a Notary Public in and for said State, do hereby certify that the within and foregoing is a true and correct copy of the original of the same, as the same appears from the records of said County.

Witness my hand and seal of office, this 1st day of May, 1904.

Notary Public in and for the State of Texas.

My Comm. Expires May 1, 1905.

Notary Public in and for the State of Texas.

My Comm. Expires May 1, 1905.

Notary Public in and for the State of Texas.

My Comm. Expires May 1, 1905.

Notary Public in and for the State of Texas.

My Comm. Expires May 1, 1905.

Notary Public in and for the State of Texas.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21034

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Paul Grover Garver				2. Date of Death Month Day Year June 23 1997		3. Time of Death 5:40AM	
	4a. Facility Name (If not institution, give street and number) Northampton Manor Nursing Home				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 219-10-8120		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 3, 1921	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Carroll		10c. City, Town or Location Union Bridge	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 42 Bucher John Rd.		10f. Zip Code 21791		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) plumber		16b. Kind of Business/Industry biotics/ subcontract w/Fed. Govt.			
	17. Father's Name (First, Middle, Last) Guy Garver				18. Mother's Name (First, Middle, Maiden Surname) Sadie Rippeon			
	19a. Informant's Name/Relationship (Type, Print) Betty J. Boone/ daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 42 Bucher John Rd. Union Bridge, MD 21791			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Locust Grove Cemetery		Date 6/25/97		20c. Location - City or Town, State nr. Mt. Airy, MD	
	21. Signature of Funeral Service Licensee <i>Katherine O. Dwyer</i>				22. Name and Address of Facility Hartzler Funeral Home Libertytown, MD			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Respiratory Failure Due to (or as a consequence of): Chronic obstructive pulm. disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Heart Failure							
	23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, tectory, officia building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier <i>Ronald E. Miller</i>				29c. License number 026499		29d. Date signed (Month, Day, Year) 6/23/97	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Ronald E. Miller 4 Culwell Dr. Mt. Airy, MD 21771							
31. Date filed (Month, Day, Year) JUN 26 1997				32. Registrar's Signature <i>J. Davidson-Randall</i>				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21035

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Antonia M Gioffre				2. Date of Death Month June Day 23 Year 1997		3. Time of Death 3:25PM	
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital				4b. City, Town, or Location of Death Clinton		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 212-20-5554		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 16, 1919	
	Usual Residence of Decedent Maryland Prince George's		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Clinton	
To Be Completed by Funeral Director	10e. Street and Number 6800 Mike Shapiro Drive		10f. Zip Code 20735		10g. Citizen of What Country? U.S.A.		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A		16b. Kind of Business/Industry N/A			
	17. Father's Name (First, Middle, Last) Fortunto Gioffre				18. Mother's Name (First, Middle, Maiden Surname) Maria Briggnti			
	19a. Informant's Name/Relationship (Type, Print) Josephine Boertlein (Sister)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6336 Johns Lane Dunkirk, Maryland 20754			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet Cemetery		20c. Location - City or Town, State Washington, D.C.		20d. Date June 26, 1997	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, MD 20735			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Bilateral Pneumonia Due to (or as a consequence of): Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Sepsis Due to (or as a consequence of): Sepsis Due to (or as a consequence of): Sepsis Due to (or as a consequence of): Sepsis Approximate Interval Between Onset and Death 48 hrs							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) N/A		28b. Time of Injury N/A M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) N/A		28d. Describe how Injury occurred N/A		28e. Location (Street and Number or Rural Route Number, City or Town, State) 7501 Summatts Rd Clinton				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Victor E. Herry MD				29c. License number D20986		29d. Date signed (Month, Day, Year) 6/24/97		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Victor Herry, MD 9131 Piscataway Road, RM 240, Clinton, MD 20735								
31. Date filed (Month, Day, Year) JUL 02 1997				32. Registrar's Signature John Andrew Randall				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

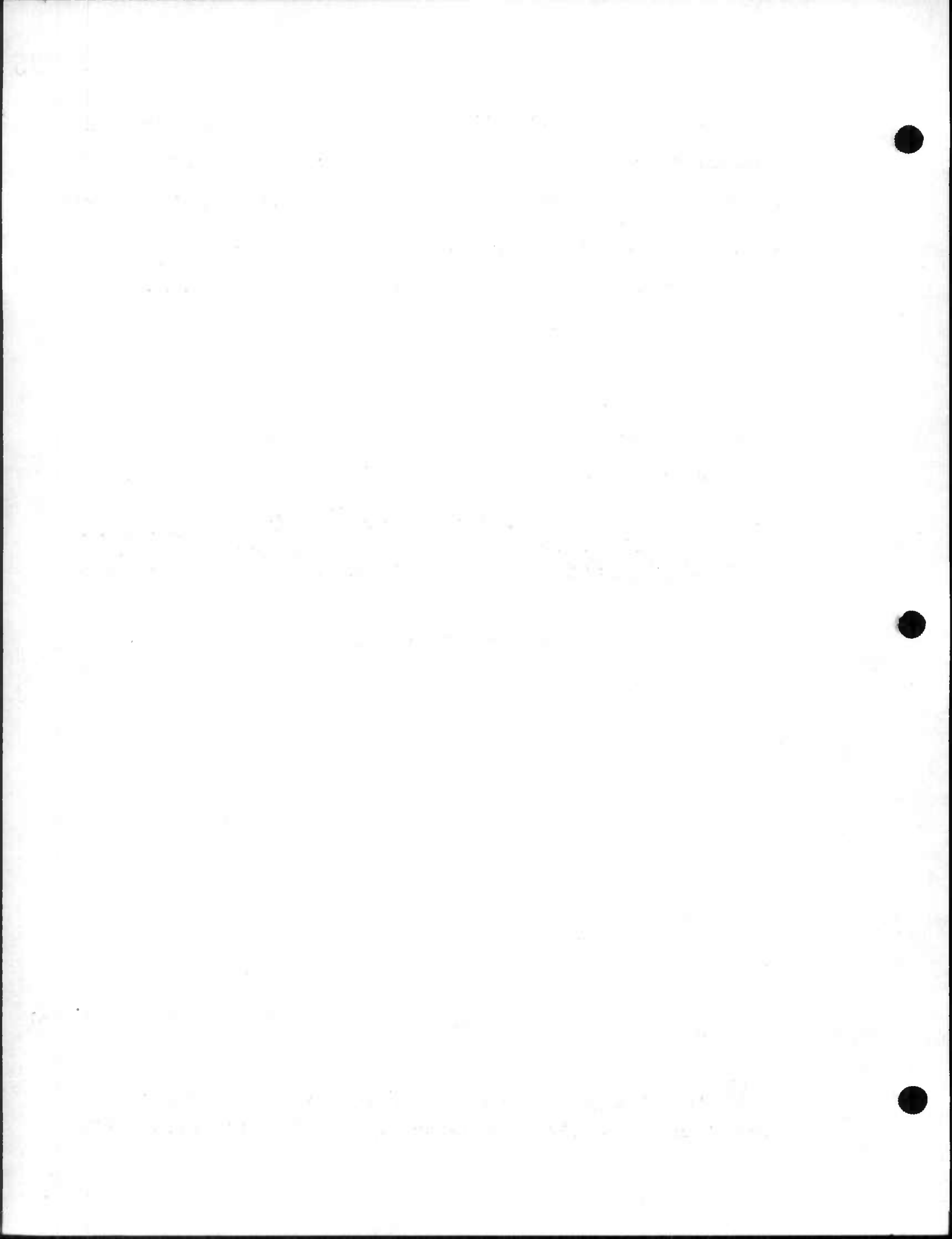
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



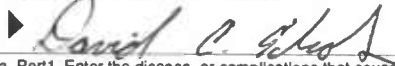
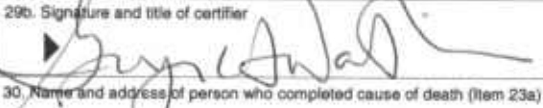
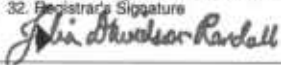
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21036

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Emogene Rice Green				2. Date of Death Month Day Year JUNE 29 1997		3. Time of Death 1:50 A:M							
	4e. Facility Name (If not institution, give street and number) PHYSICIANS MEMORIAL HOSPITAL				4b. City, Town, or Location of Death LAPLATA		4c. County of Death CHARLES							
Funeral Director	5. Social Security Number 407-22-7733		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 21 1915							
	9. Birthplace (State or Foreign Country) Kentucky		10a. State MD		10b. County Charles		10c. City, Town or Location Cobb Island							
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 17719 Duval St.									
	10f. Zip Code 20625				10g. Citizen of What Country? U.S.A.									
To Be Completed by Physician/Medical Examiner	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Home									
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Robert Rice				18. Mother's Name (First, Middle, Maiden Surname) Edna Short Rice									
	19a. Informant's Name/Relationship (Type, Print) Rebecca Dickerson				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 247 Cobb Island, MD 20625									
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crem.		20c. Date 7/1/97		20d. Location - City or Town, State Alexandria, VA							
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility AREHART-ECHOLS FUNERAL HOME, INC. MO0945 P.O. Box 567 LaPlata, MD 20646											
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute Ventricular Arrhythmia with Cardiac Arrest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Advanced Aortic Stenosis Refractory Congestive Heart Failure								Approximate Interval Between Onset and Death arrived x yrs.					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred					
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)											
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29b. Signature and title of certifier 		29c. License number D-20629		29d. Date signed (Month, Day, Year) 6/29/97	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEORGE WATHEN MD 11345 PEMBROKE SQUARE SUITE 103 WILDFORD, MD 20603								31. Date filed (Month, Day, Year) JUL 02 1997		32. Registrar's Signature 			

97 21037

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CLAUDE WESLEY HALL				2. DATE OF DEATH MONTH DAY YEAR JUNE 29, 1997		3. TIME OF DEATH 2:50 AM	
4. SOCIAL SECURITY NUMBER 220-10-8496		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 84 YRS.	7. DATE OF BIRTH (Month, Day, Year) 03/29/1913		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) PO BOX 158				9b. CITY, TOWN OR LOCATION OF DEATH UPPER FAIRMOUNT		9c. COUNTY OF DEATH SOMERSET	
10a. STATE MARYLAND		10b. COUNTY SOMERSET		10c. CITY, TOWN OR LOCATION UPPER FAIRMOUNT		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER PO BOX 158				10f. ZIP CODE 21867		10g. CITIZEN OF WHAT COUNTRY? U.S.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HEAVY EQUIPMENT OPERATOR		16b. KIND OF BUSINESS/INDUSTRY COUNTY ROADS			
17. FATHER'S NAME (First, Middle, Last) HARRY B. HALL				18. MOTHER'S NAME (First, Middle, Maiden Surname) FLORENCE BYRD			
19a. INFORMANT'S NAME (Type/Print) HARRY FRANKLIN HALL				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30185 CURTISS ROAD, MECHANICSVILLE, MD. 20659			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BEECHWOOD CEMETERY		20c. LOCATION — City or Town, State 07/01/97 PRINCESS ANNE, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> MD0295				22. NAME AND ADDRESS OF FACILITY HINMAN FUNERAL HOME 11673 SOMERSET AVE., PRINCESS ANNE, MD. 21853			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. metastatic prostate CA DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death ~3yrs Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER H42911		29d. DATE SIGNED (Month, Day, Year) 6/30/97	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 500 Market St Pocomoke MD							
31. DATE FILED (Month, Day, Year) 6/30/97				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21038

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN HINDMAN				2. Date of Death Month Day Year JUN 26 1997		3. Time of Death 4 10 PM	
	4a. Facility Name (If not institution, give street and number) UNIVERSITY OF MARYLAND HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death	
Funeral Director	5. Social Security Number 212-16-8830		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) Dec 2 1921	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Cecil		10c. City, Town or Location Rising Sun	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 117 Cooper St.		10f. Zip Code 21911		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Postal Clerk		16b. Kind of Business/Industry U S Post Office			
	17. Father's Name (First, Middle, Last) John C. Hindman, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Margaret G. Reeder			
	19a. Informant's Name/Relationship (Type, Print) Dorothy H. Brokaw, Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 119 Reynolds Ave Rising Sun MD 21911			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Brookview Cemetery June 28 1997		20c. Location - City or Town, State Rising Sun MD			
	21. Signature of Funeral Service Licensee Richard L. Goodie		22. Name and Address of Facility R. T. Foard Funeral Home 111 S Queen St. Rising Sun MD 21911					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Cerebral herniation syndrome Due to (or as a consequence of): b. Intracerebral hemorrhage Due to (or as a consequence of): c. Hypertension Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 1 days 7 days							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
							24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28e. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier Eric A. Potts MD				29c. License number P09779		29d. Date signed (Month, Day, Year) JUN 26 1997	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERIC A POTTS 22 S GREENE ST S-12-D BALTIMORE, MD 21201							
31. Date filed (Month, Day, Year) JUN 30 1997				32. Registrar's Signature Davidson-Randall				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21039

Item:8 per FH G-750 8/14/97 dh

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Thomas Henry Hodgson			2. Date of Death Month June Day 24 Year 1997		3. Time of Death 03:00	
	4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital			4b. City, Town, or Location of Death Prince Frederick		4c. County of Death Calvert	
Funeral Director	5. Social Security Number 024 60 3445		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 32 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 1965 (Month, Day, Year) February 3 1986
	9. Birthplace (State or Foreign Country) Massachusetts						
To Be Completed by Funeral Director	10a. State Maryland		10b. County Calvert		10c. City, Town or Location 693 Running Fox Road Lusby		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 693 Running Fox Road			10f. Zip Code 20657		10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Date 86-95		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) computer analyst		16b. Kind of Business/Industry US Government		
	17. Father's Name (First, Middle, Last) Herbert Hodgson			18. Mother's Name (First, Middle, Maiden Surname) Clarice I Scott			
	19a. Informant's Name/Relationship (Type, Print) Rhonda Hodgson- wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 693 Running Fox Rd. Lusby Maryland 20657			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Funeral Service		Date June 27 1997		20c. Location - City or Town, State Alexandria Virginia
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Rausch Funeral Home 20676 4405 Broomes Island Rd. Port Republic Maryland			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ASCVD Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
	Approximate Interval Between Onset and Death unk						
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier 		29c. License number 047610		29d. Date signed (Month, Day, Year) 6/24/97		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. David Tardio Prince Frederick, MD. 20678						
State Registrar	31. Date filed (Month, Day, Year) JUN 26 1997		32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

541

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21040

Amend 10b, Calvert, 6/23/97, drw

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Richard O Hunt, Sr.

2. Date of Death

June 18 1997 8:45 pm

3. Time of Death

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

579 38 3688

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 19, 1930

9. Birthplace (State or Foreign Country)

Wash., DC

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

North Beach

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4100 Chestnut Ave.

10f. Zip Code

20714

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1952-5413. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

8

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

sheet metal worker

16b. Kind of Business/Industry

construction

17. Father's Name (First, Middle, Last)

William

Hunt

18. Mother's Name (First, Middle, Maiden Surname)

Mary

Baldwin

19a. Informant's Name/Relationship (Type, Print)

Andrew L. Hunt/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4100 8th Street, North Beach, MD 20714

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Resurrection Cemetery

Date

6-23-97

20c. Location - City or Town, State

Clinton, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rausch Funeral Home, Owings, MD 20736

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and Death

e. ASPIRATION PNEUMONIA.

Due to (or as a consequence of):

b. EXACERBATION OF CHRONIC BRONCHITIS

Due to (or as a consequence of):

c. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

MD D45149

29d. Date signed (Month, Day, Year)

JUNE 18 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ONABAYO B 301 HOSPITAL DRIVE. GLEN BURNIE MD 21061

31. Date filed (Month, Day, Year)

JUN 20 1997

32. Registrar's Signature

Julia Anderson-Randall

State

Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21041

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Annie Catherine Hebb				2. Date of Death Month Day Year June 1, 1997		3. Time of Death 2:30 AM		
	4a. Facility Name (If not institution, give street and number) Bayside Nursing Center				4b. City, Town, or Location of Death Lexington Park		4c. County of Death St. Mary's		
Funeral Director	5. Social Security Number 219-54-6085	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) December 27, 1932		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland	10b. County St. Mary's	10c. City, Town or Location Compton			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 22355 New Town Neck Road			10f. Zip Code 20627		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry N/A			
	17. Father's Name (First, Middle, Last) William McLain Dorsey				18. Mother's Name (First, Middle, Maiden Surname) Lucy Bolt				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mary G. Hebb-Price Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21488 Exquisite Court, Lexington Park, MD 20653					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Zion United Methodist		Date 6/6/97		20c. Location - City or Town, State Lexington Park, MD		
	21. Signature of Funeral Service Licensee Edward M. Brinsfield JR. M00052			22. Name and Address of Facility Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, MD 20650					
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Cardiac Arrest Cardiac Arrhythmia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Approximate Interval Between Onset and Death minutes minutes								
	23b. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Cancer of Brain								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier James P. Jarboe, M.D.							
29c. License number D 06419		29d. Date signed (Month, Day, Year) 6-2-97							
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) James P. Jarboe, M.D. Leonardtown, Maryland 20650									
31. Date filed (Month, Day, Year) JUN 03 1997		32. Registrar's Signature John Davidson Randall							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21042

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gertrude Harvin				2. Date of Death Month 06 Day 23 Year 97		3. Time of Death 01:55	
	4a. Facility Name (If not Institution, give street and number) Manier Health Care Center				4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 578 522 719		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 66 Yrs.		8. Date of Birth (Month, Day, Year) 06-28-30	
	9. Birthplace (State or Foreign Country) SC		10a. State D. C.		10b. County WASHINGTON		10c. City, Town or Location WASHINGTON	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 5703 EAST CAPITOL ST., S. E.		10f. Zip Code 20019		10g. Citizen of What Country? U. S. A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7TH GRADE College (1-4or 5+) HOMEMAKER		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry Own Home				
17. Father's Name (First, Middle, Last) HENRY JAMES				18. Mother's Name (First, Middle, Maiden Surname) MYRA MILES				
19a. Informant's Name/Relationship (Type, Print) BENNIE HARVIN - HUSBAND				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5703 EAST CAPITOL ST., S. E. D. C. 20019				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CANE SAVANNAH CEMETERY		20c. Location - City or Town, State 6/28 WEDGEFIELD, SC				
21. Signature of Funeral Service Licensee <i>Theodore C. Pinckney</i>				22. Name and Address of Facility PINCKNEY-SPANGLER FUNERAL HOME 524 - 8TH ST., N. E. WASH., D. C. 20002				
23a. Pert. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. aspiration pneumonia Due to (or as a consequence of): b. cerebrovascular accident Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. diabetes, hypertension, depression hypertension								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>Robert R. Goodstein M</i>		29c. License number 003581		29d. Date signed (Month, Day, Year) June 23 1997				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 9410 Old Georgetown RD. Bethesda MD								
31. Date filed (Month, Day, Year) JUN 24 1997		32. Registrar's Signature <i>John Anderson</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the report

describes the general situation of the country

and the results of the survey

2. The second part of the report

describes the results of the survey

3. The third part of the report

describes the results of the survey

4. The fourth part of the report

describes the results of the survey

5. The fifth part of the report

describes the results of the survey

6. The sixth part of the report

describes the results of the survey

7. The seventh part of the report

describes the results of the survey

8. The eighth part of the report

describes the results of the survey

9. The ninth part of the report

describes the results of the survey

10. The tenth part of the report

describes the results of the survey

11. The eleventh part of the report

describes the results of the survey

12. The twelfth part of the report

describes the results of the survey

13. The thirteenth part of the report

describes the results of the survey

14. The fourteenth part of the report

describes the results of the survey

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

97 21043

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JAMES WILLIAM HUBER					2. Date of Death Month JUN Day 17 Year 1997		3. Time of Death 5:06 PM		
	4e. Facility Name (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER					4b. City, Town, or Location of Death BETHESDA		4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 050 32 3337		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 57 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 26, 1940		9. Birthplace (State or Foreign Country) New York	
	Usual Residence of Decedent									
10a. State Maryland			10b. County Prince George's		10c. City, Town or Location Upper Marlboro			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 14416 Colonel Fernwick Court					10f. Zip Code 20772		10g. Citizen of What Country? United States			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 57-77		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Security			16b. Kind of Business/Industry U.S. Government		
17. Father's Name (First, Middle, Last) Lawrence F. Huber					18. Mother's Name (First, Middle, Maiden Surname) Mary Lucille Olive Wilson					
19a. Informant's Name/Relationship (Type, Print) Diana L. Huber Wife					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14416 Colonel Fernwick Court Upper Marlboro Md.					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery			20c. Location - City or Town, State Cheltenham Maryland		20d. Date June 23, 1997		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715					
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p align="center">e. PNEUMONIA</p> <p align="center">Due to (or as a consequence of):</p> <p align="center">b. METASTATIC LUNG CANCER</p> <p align="center">Due to (or as a consequence of):</p> <p align="center">c. _____</p> <p align="center">Due to (or as a consequence of):</p> <p align="center">d. _____</p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p>_____ days</p> <p>_____ months</p> </div> </div> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier 			29c. License number D-51503		29d. Date signed (Month, Day, Year) 06/18/97		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DAVID BLAZES, LT, MC, USN					30. Name and address of person who completed cause of death (Item 23e) (Type, Print) NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600					
31. Date filed (Month, Day, Year) JUN 24, 1997					32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

87 21044

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) TIMOTHY J. HUBER					2. Date of Death Month 6 Day 25 Year 94		3. Time of Death 0543A		
	4a. Facility Name (If not institution, give street and number) ATLANTIC GEN HOSPITAL					4b. City, Town, or Location of Death BERLIN Md.		4c. County of Death WORCESTER		
Funeral Director	5. Social Security Number 195-54-9382		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs., last birthday) 36 Yrs.		8. Date of Birth (Month, Day, Year) 8-20-60		9. Birthplace (State or Foreign Country) Pa., U.S.	
	Usual Residence of Decedent									
10a. State Pa.		10b. County Washington		10c. City, Town or Location Venetia				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 123 Bower Hill Road					10f. Zip Code 15367		10g. Citizen of What Country? US			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collega (1-4or 5+) 					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Florist			16b. Kind of Business/Industry Floral		
17. Father's Name (First, Middle, Last) Richard Huber					18. Mother's Name (First, Middle, Maiden Surname) Dorothy Ptaszkiewicz					
19a. Informant's Name/Relationship (Type, Print) Crystal Huber (wife)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 123 Bower Hill Rd., Venetia, Pa. 15367					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Beinhauer Crematory			20c. Location - City or Town, State 6-28-97 Bridgeville, Pa.				
21. Signature of Funeral Service Licensee <i>[Signature]</i> Moorsy					22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, Md. 21811					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. ACUTE MYOCARDIAL INFARCTION</p> <p>b. ARTERIOSCLEROTIC HEART DISEASE</p> <p>c. </p> <p>d. </p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p>11 MINS</p> </div> </div>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier Roy Cragway Jr. M.D.					29c. License number D28466		29d. Date signed (Month, Day, Year) 6/25/94			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROY CRAGWAY JR. M.D. 9733 HEATHWAY DR. BERLIN Md 21811										
31. Date filed (Month, Day, Year) JUN 27 1997					32. Registrar's Signature <i>[Signature]</i>					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97-21045

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William Archer Harrison Jr.				2. Date of Death Month: 6 Day: 20 Year: 97		3. Time of Death 9:48A.M.		
	4a. Facility Name (If not institution, give street and number) Prince Georges Hospital				4b. City, Town, or Location of Death Cheverly		4c. County of Death P.G.		
Funeral Director	5. Social Security Number 579-38-1713		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 64 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 15, 1932		
	9. Birthplace (State or Foreign Country) Virginia		10a. State MD		10b. County P.G.		10c. City, Town or Location Ft. Washington		
To Be Completed by Funeral Director		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 6801 Bock Rd		10f. Zip Code 20744	
		10g. Citizen of What Country? U.S.A.		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
To Be Completed by Physician/Medical Examiner		14. Race - American Indian, Black, White, etc. Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+):		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cab Driver		16b. Kind of Business/Industry Private	
		17. Father's Name (First, Middle, Last) William Archer Harrison Sr.		18. Mother's Name (First, Middle, Maiden Surname) Geneva Geer		19a. Informant's Name/Relationship (Type, Print) Hazel Harrison		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6801 Bock Rd. Ft. Wash. MD. 20744	
Physician /Medical Examiner		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Cemetery		20c. Location - City or Town, State Landover, Md.		20d. Date 6/25/97	
		21. Signature of Funeral Service Licensee <i>Janice Edwards</i>		22. Name and Address of Facility Hodges and Edwards 3910 Silver Hill RD. Suitland, Md.		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SEPTIC SHOCK. Due to (or as a consequence of): b. Respiratory Failure. Due to (or as a consequence of): c. CHF. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death 2-days. > 3-months	
Medical Certification: To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. STROKE;						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
State Registrar		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
State Registrar		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>	
		29c. License number D-34525		29d. Date signed (Month, Day, Year) 06-20-97.		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S.J. Rao, MD - 4000-Mitchellville Road; #220; Bowie-MD-20716.		31. Date filed (Month, Day, Year) JUN 23 1997	
State Registrar		32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21046

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MYRTLE L. HARPER

2. Date of Death

Month Day Year

JUNE 30 1997

3. Time of Death

4:15 PM

4e. Facility Name (If not institution, give street and number)

CHARLES COUNTY NURSING HOME

4b. City, Town, or Location of Death

LA PLATA

4c. County of Death

CHARLES

Funeral
Director

5. Social Security Number

227-09-1567

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year

May 5-13-1913

9. Birthplace (State or Foreign Country)

Washington

Usual Residence of Decedent

10a. State
Maryland Prince George's

10b. County

Upper Marlboro

10c. City, Town or Location

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12404 Apple Court

10f. Zip Code

20772

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Office Worker

16b. Kind of Business/Industry

The Carpenters Union

17. Father's Name (First, Middle, Last)

William Leonard Church

18. Mother's Name (First, Middle, Maiden Surname)

Callie Phillips

19a. Informant's Name/Relationship (Type, Print)

Juanita Noone

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12404 Apple Court, Upper Marlboro, Md 20772

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Rd, Clinton, Md 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Unknown

Due to (or as a consequence of):

Dehydration

Due to (or as a consequence of):

Fever

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

96 hrs

24 hrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Parkinson's Disease

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

MD - 448230

29d. Date signed (Month, Day, Year)

June 30, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

D.H. JERKINS MD, 1317 LaPlata Ave, LaPlata Md

State
Registrar

31. Date filed (Month, Day, Year)

JUL 02 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

Page 1

Page 2

Page 3

Page 4

Page 5

Page 6

Page 7

Page 8

Page 9

Page 10

Page 11

Page 12

Page 13

Page 14


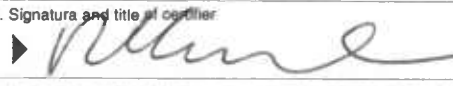
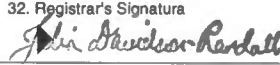
Page 15

Page 16

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 21047**
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Raymond Kerry Horner				2. Date of Death Month June Day 26 Year 1997		3. Time of Death 1530	
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 229-38-9776		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 63 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 23, 1933 Virginia	
	10a. State VA.		10b. County Accomack		10c. City, Town or Location Hallwood		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 27335 Main Street				10f. Zip Code 23359		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Veteran		16b. Kind of Business/Industry U.S. Coast Guard	
	17. Father's Name (First, Middle, Last) Frank Leslie Horner				18. Mother's Name (First, Middle, Maiden Surname) Mildred Fish			
	19a. Informant's Name/Relationship (Type, Print) Nancy P. Horner				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27335 Main St., Hallwood, VA. 23359			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) J.W. Taylor Memorial Cem.		20c. Date 6/28/97		20d. Location - City or Town, State Temperanceville, VA.	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Williams-Parksley Funeral Home 25046 Parksley Rd., Parksley, VA. 23421			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PULMONARY FIBROSIS Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28e. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number 046080		29d. Date signed (Month, Day, Year) 6/26/97		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert T. Chasse M.D. 100 E. Carroll St. Salisbury M.D.								
31. Date filed (Month, Day, Year) JUL 03 1997				32. Registrar's Signature 				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21048

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Viola B. Howard				2. Date of Death Month Day Year June 23, 1997		3. Time of Death 6:35 AM				
	4e. Facility Name (If not institution, give street and number) Fairland Adventist Nursing Center				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery				
Funeral Director	5. Social Security Number 129-24-4734		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 96 Yrs.		8. Date of Birth (Month, Day, Year) 12/1/00		9. Birthplace (State or Foreign Country) Georgia		
	Usual Residence of Decedent										
10a. State Md.		10b. County Montgomery		10c. City, Town or Location Silver Spring				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 11700 Old Columbia Pike # 2014				10f. Zip Code 20904		10g. Citizen of What Country? U.S.A.					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3rd College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic			16b. Kind of Business/Industry Private Industry				
17. Father's Name (First, Middle, Last) Joseph Daymon				18. Mother's Name (First, Middle, Maiden Surname) Fannie M. DeVaughn							
19e. Informant's Name/Relationship (Type, Print) Reliford T. Byrd/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as # 13 above							
20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Glenwood Cem.		Date 6/28/97		20c. Location - City or Town, State Wash., D.C.					
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility H.S. Washington & Sons, Inc. 4925 Burroughs Ave., N.E.							
23a. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. CEREBROVASCULAR ACCIDENT Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death ~ 2 days			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
								24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier 				29c. License number D-17874		29d. Date signed (Month, Day, Year) 6-23-97					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. M. NAYAR, MD 3717-38th AVE COTTAGE CITY, MD 20722											
31. Date filed (Month, Day, Year) JUN 27 1997				32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21049

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George Ellison Ireland				2. Date of Death Month June Day 22 Year 1997		3. Time of Death 2300	
	4e. Facility Name (If not institution, give street and number) Union Hospital of Cecil County				4b. City, Town, or Location of Death Elkton		4c. County of Death Cecil	
Funeral Director	5. Social Security Number 217-18-1596		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 4, 1922	
	9. Birthplace (State or Foreign Country) Maryland		10. Usual Residence of Decedent		11. Under 1 Year Months 74 Days		12. Under 24 Hrs. Hours 74 Min.	
To Be Completed by Funeral Director	10a. State Maryland		10b. County Cecil		10c. City, Town or Location Chesapeake City		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 309 Bohemia Avenue				10f. Zip Code 21915		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanic		16b. Kind of Business/Industry Automotive	
	17. Father's Name (First, Middle, Last) George Washington Ireland				18. Mother's Name (First, Middle, Maiden Surname) Helen Ellison			
	19a. Informant's Name/Relationship (Type, Print) Naomi Ireland - Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 416 - Chesapeake City, MD 21915			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bethel Cemetery		20c. Date 6-26		20d. Location - City or Town, State Chesapeake City, MD	
	21. Signature of Funeral Service Licensee <i>Donna S. Hicks</i>				22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street - Elkton, MD 21921-5521			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Metastatic Non-Small Cell Lung Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) NA		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury: At home, farm, street, factory, office building, etc. (Specify) NA		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>Martha Hosford Skapof M.D.</i>				29c. License number C100002768		29d. Date signed (Month, Day, Year) 6/26/97		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Martha A. Hosford-Skapof, M.D. - 111 W. High Street - Elkton, MD 21921								
31. Date filed (Month, Day, Year) JUN 27 1997				32. Registrar's Signature <i>Julia Davidson-Randall</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Ireland, George
Division of Vital Records, P.O. Box 68760,

6+11A

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

21050

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Kenneth Lawrence Irwin, Sr.					2. Date of Death Month May Day 30 Year 1997		3. Time of Death 6:00 PM	
	4a. Facility Name (If not institution, give street and number) 18955 McKays Cove Lane					4b. City, Town, or Location of Death Leonardtwn		4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 143-18-1128		6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 6, 1924		9. Birthplace (State or Foreign Country) New Jersey
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Leonardtwn			10d. Inside City Limits 1 Yes 2 No	
	10e. Street and Number 18955 McKays Cove Lane				10f. Zip Code 20650		10g. Citizen of What Country? United States		
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1942-1963		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Civil Servant			16b. Kind of Business/Industry U.S. Government		
	17. Father's Name (First, Middle, Last) Edwin L. Irwin					18. Mother's Name (First, Middle, Maiden Sumama) Elizabeth Hammell			
	19a. Informant's Name/Relationship (Type, Print) Lorraine K. Irwin Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18955 McKays Cove Lane, Leonardtown, MD 20650				
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date 6/2/97		20c. Location - City or Town, State Alexandria, Virginia	
	21. Signature of Funeral Service Licensee Edward N. Brinsfield, Jr. M00052			22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p> </div> <div style="width: 60%;"> <p>a. Left ventricular Failure - ~2 months Due to (or as a consequence of):</p> <p>b. Coronary Artery Disease ~2 yrs Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____ Due to (or as a consequence of):</p> </div> </div>								
	23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown								
24a. Was an autopsy performed? 1 Yes 2 No							24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No		
25. Was case referred to medical examiner? 1 Yes 2 No					26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)				
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined			28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					29b. Signature and title of certifier KIRAN D. MANTA				
29c. License number D36206					29d. Date signed (Month, Day, Year) 05/31/97				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KIRAN D. MANTA									
31. Date filed (Month, Day, Year) JUN 03 1997					32. Registrar's Signature John Davidson Randall				

Baltimore, Maryland 21215-0020

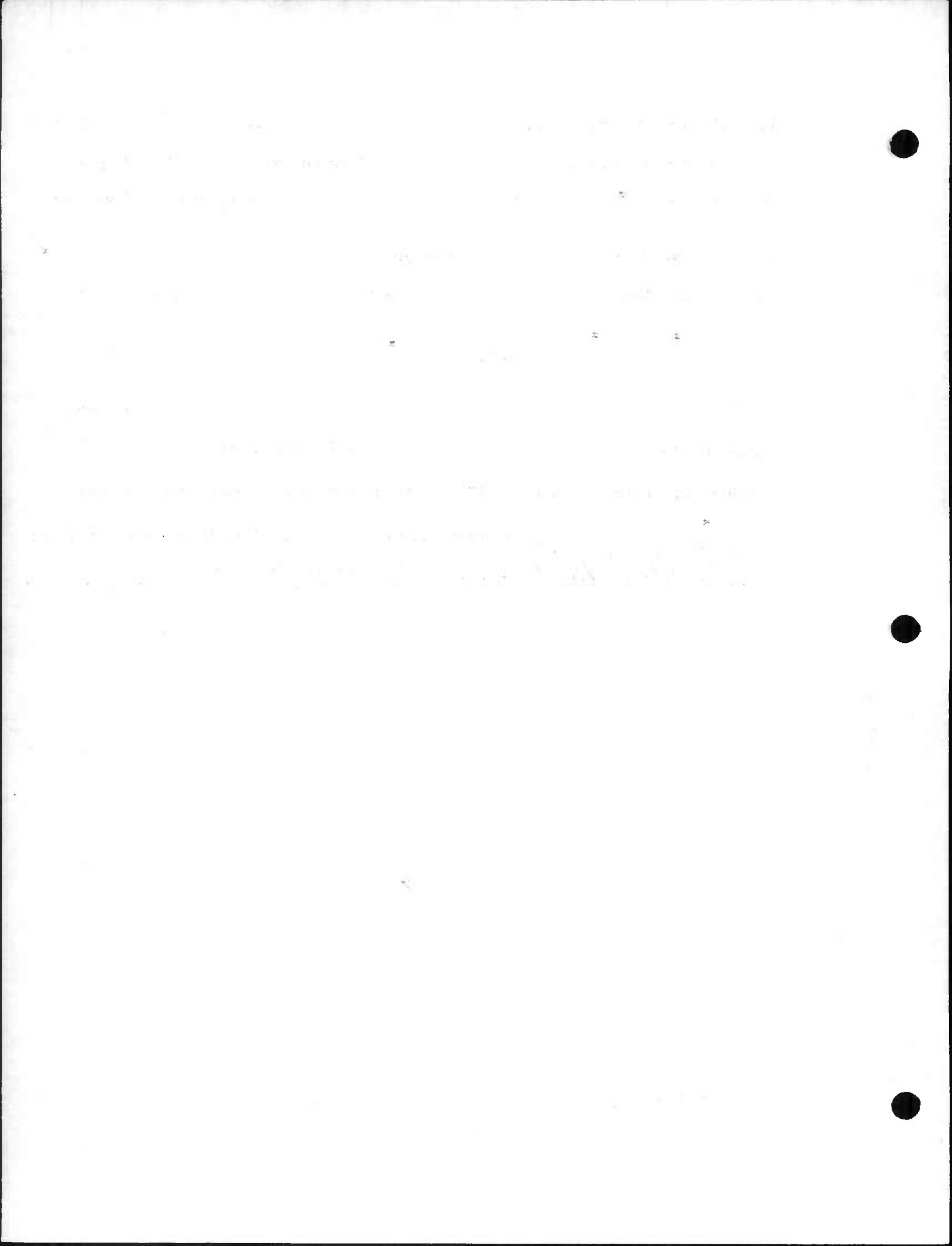
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

97 21051

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Leola Johnson</i>				2. Date of Death Month <i>June</i> Day <i>17</i> Year <i>1997</i>				3. Time of Death <i>7:39pm</i>				
	4a. Facility Name (If not institution, give street and number) <i>Southern Maryland Hospital</i>				4b. City, Town, or Location of Death <i>Clinton</i>				4c. County of Death <i>Prince George's</i>				
Funeral Director	5. Social Security Number <i>213-42-8468</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>56</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>November 18, 1940</i>		9. Birthplace (State or Foreign Country) <i>Maryland</i>				
	Usual Residence of Decedent												
10a. State <i>Maryland</i>		10b. County <i>Prince George's</i>		10c. City, Town or Location <i>Upper Marlboro</i>						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number <i>13304 Van Brady Road</i>				10f. Zip Code <i>20772</i>				10g. Citizen of What Country? <i>USA</i>					
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4or 5+)				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Cosmetologist</i>				16b. Kind of Business/Industry <i>Self-Employed</i>					
17. Father's Name (First, Middle, Last) <i>John Oliver Windsor</i>						18. Mother's Name (First, Middle, Maiden Surname) <i>Leora Brownon</i>							
19e. Informant's Name/Relationship (Type, Print) <i>Alphonsus Johnson Husband</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>13304 Van Brady Road Upper Marlboro Maryland 20772</i>									
20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Washington National Cemetery</i>				Date <i>June 23, 1997</i>		20c. Location - City or Town, State <i>Suitland, Maryland</i>			
21. Signature of Funeral Service Licensee <i>Lloyd M. Cate</i>				22. Name and Address of Facility <i>Adams Funeral Home 20605 Aquasco Road Aquasco Maryland 20608</i>									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Cancer of colon</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last												Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28e. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>C.V. Johnson M.D.</i>				29c. License number <i>D14767</i>		29d. Date signed (Month, Day, Year) <i>6/18/97</i>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Cyrus R. Parset MD. 8700 Old Branch Ave Clinton MD 20735</i>													
31. Date filed (Month, Day, Year) <i>JUN 27 1997</i>				32. Registrar's Signature <i>John Davidson Randall</i>									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21052

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

REGINA DOROTHY JAMES

2. Date of Death
Month Day Year

June 17 1997

3. Time of Death

1:35 AM.

4a. Facility Name (If not institution, give street and number)

St. Mary's Hospital

4b. City, Town, or Location of Death

Leonardtown

4c. County of Death

St. Mary

5. Social Security Number

214-32-8924

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

63

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

August 14, 1933

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

St. Mary

10c. City, Town or Location

Hollywood

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

24485 Mt. Pleasant Rd.

10f. Zip Code

20636

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give X
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Post Master

16b. Kind of Business/Industry

U.S. Postal Service

17. Father's Name (First, Middle, Last)

Thomas Alvin Hayden

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Frances Garner

19a. Informant's Name/Relationship (Type, Print)

Patricia A. Hayden/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

24465 Lefty Lane, Hollywood, MD 20636

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

St. John's Cemetery

Date

6/20/97 Hollywood, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Michael L. Gardiner

22. Name and Address of Facility

Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270, Leonardtown, MD 2065023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)e. Metastatic Adenocarcinoma
of Colon
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

1 yr

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

DAVID ALLEN M.D.

29c. License number

D25230

29d. Date signed (Month, Day, Year)

6/17/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DAVID ALLEN M.D.

LEONARDTOWN, MD. 20650

31. Date filed (Month, Day, Year)

JUN 18 1997

32. Registrar's Signature

John Davidson Randall

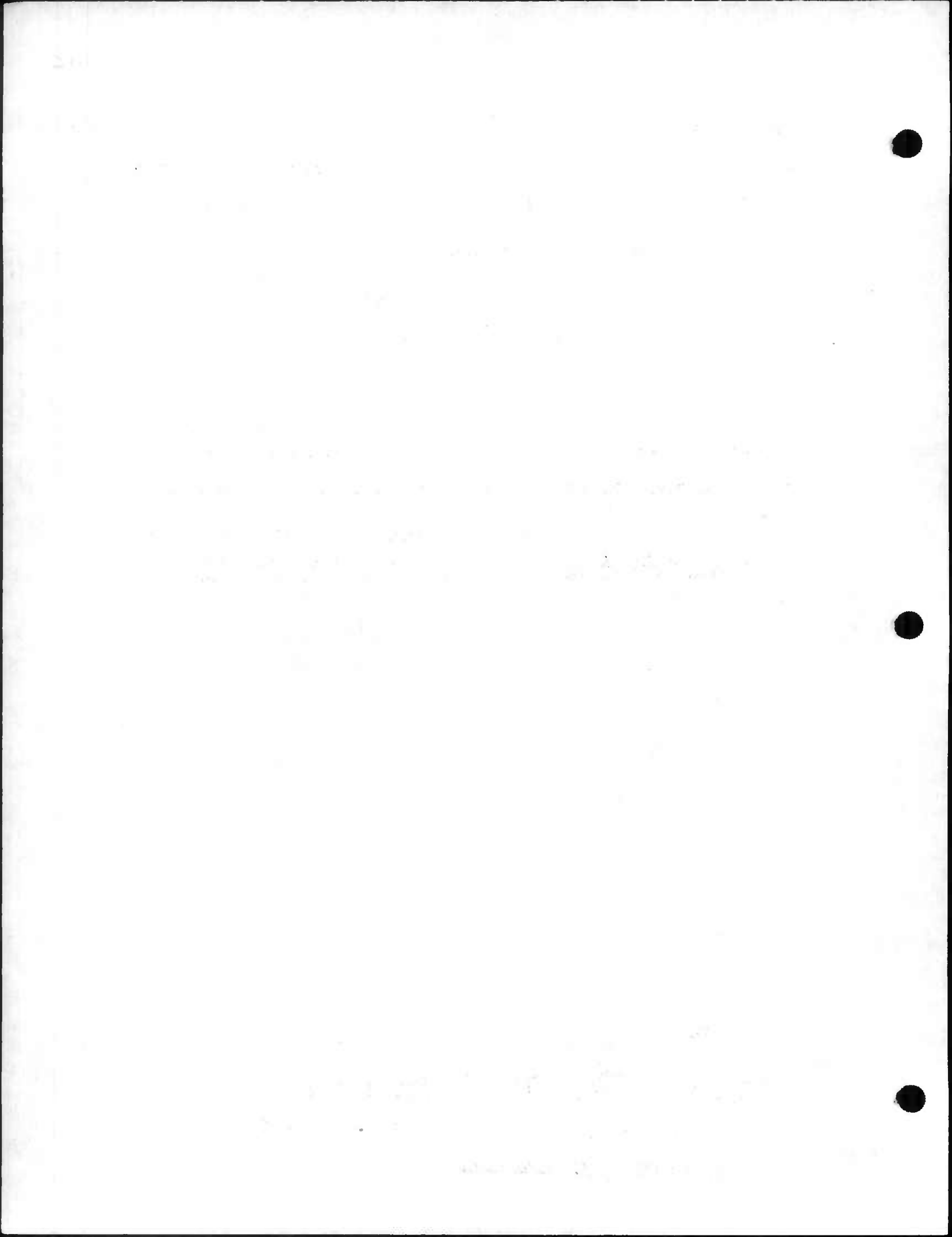
State
RegistrarBaltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

REGINA JAMES



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21053

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Anna Jenifer

2. Date of Death

Month Day Year
June 14 1997

3. Time of Death

2:15 p.m.

4a. Facility Name (If not institution, give street and number)

Deaton University of Maryland Medicine

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral
Director

5. Social Security Number

218-76-3947

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 15, 1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Lexington Park

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

127 Essex Drive

10f. Zip Code

20653

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

0

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Gene Carter/Guardian

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 653, Leonardtown, MD 20650

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Our Ladys Cemetery

Date

6/17/97

20c. Location - City or Town, State

Leonardtown, MD

21. Signature of Funeral Service Licensee

Michael K. Gardner

22. Name and Address of Facility

Mattingley-Gardiner Funeral Home, P.A.

P.O. Box 270, Leonardtown, Maryland 20650

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Sepsis.

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 day

b.

Aspiration pneumonia.

Due to (or as a consequence of):

1 day.

c.

Diabetes mellitus

Due to (or as a consequence of):

2 yrs.

d.

Hypertension

Several yrs.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury et
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Michael K. Gardner

29c. License number

D34974.

29d. Date signed (Month, Day, Year)

6-16-97.

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

5865 Robert Oliver place, #121, Columbia, MD 21045

31. Date filed (Month, Day, Year)

JUN 18 1997

32. Registrar's Signature

*Jahid Abdullah-Rahall*State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21054

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) TYRE' MARCEL JONES				2. Date of Death Month Day Year JUNE 23, 1997		3. Time of Death 23:15 PM	
	4a. Facility Name (If not institution, give street and number) ROUTE 214 WEST AND ADVENTURE WORLD				4b. City, Town, or Location of Death LARGO		4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 578-15-4051		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 15 Yrs.		8. Date of Birth (Month, Day, Year) NOV. 30, 1981	
	9. Birthplace (State or Foreign Country) CHEVERLY, MD		10a. State MD		10b. County PRINCE GEORGES		10c. City, Town or Location UPPER MARLBORO	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number # 25 LAUGHTON STREET		10f. Zip Code 20744		10g. Citizen of What Country? USA	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+) 0		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) STUDENT		16b. Kind of Business/Industry EDUCATIONAL			
	17. Father's Name (First, Middle, Last) THOMAS JONES				18. Mother's Name (First, Middle, Maiden Surname) SYLVIA EARL			
	19a. Informant's Name/Relationship (Type, Print) MOTHER MRS. SYLVIA EARL-MACKLIN				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) # 25 LAUGHTON STREET UPPER MARLBORO, MD 20744			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HARMONY MEMORIAL PARK		Date 6/30/97		20c. Location - City or Town, State LANDOVER, MD	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility ALEXANDER S. POPE FUNERAL HOMES 5538 MARLBORO PIKE FORESTVILLE, MD 20747			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Multiple Injuries Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE								
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide								
28a. Date of Injury (Month, Day Year) 6-23-97 28b. Time of Injury 10 15 PM 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred Pedestrian struck by Autos								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Roadway 28f. Location (Street and Number or Rural Route Number, City or Town, State) RT 214								
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>[Signature]</i> 29c. License number OCME 29d. Date signed (Month, Day, Year) JUNE 24, 1997								
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) JUN 26 1997 32. Registrar's Signature <i>[Signature]</i>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21055

Certificate of Death

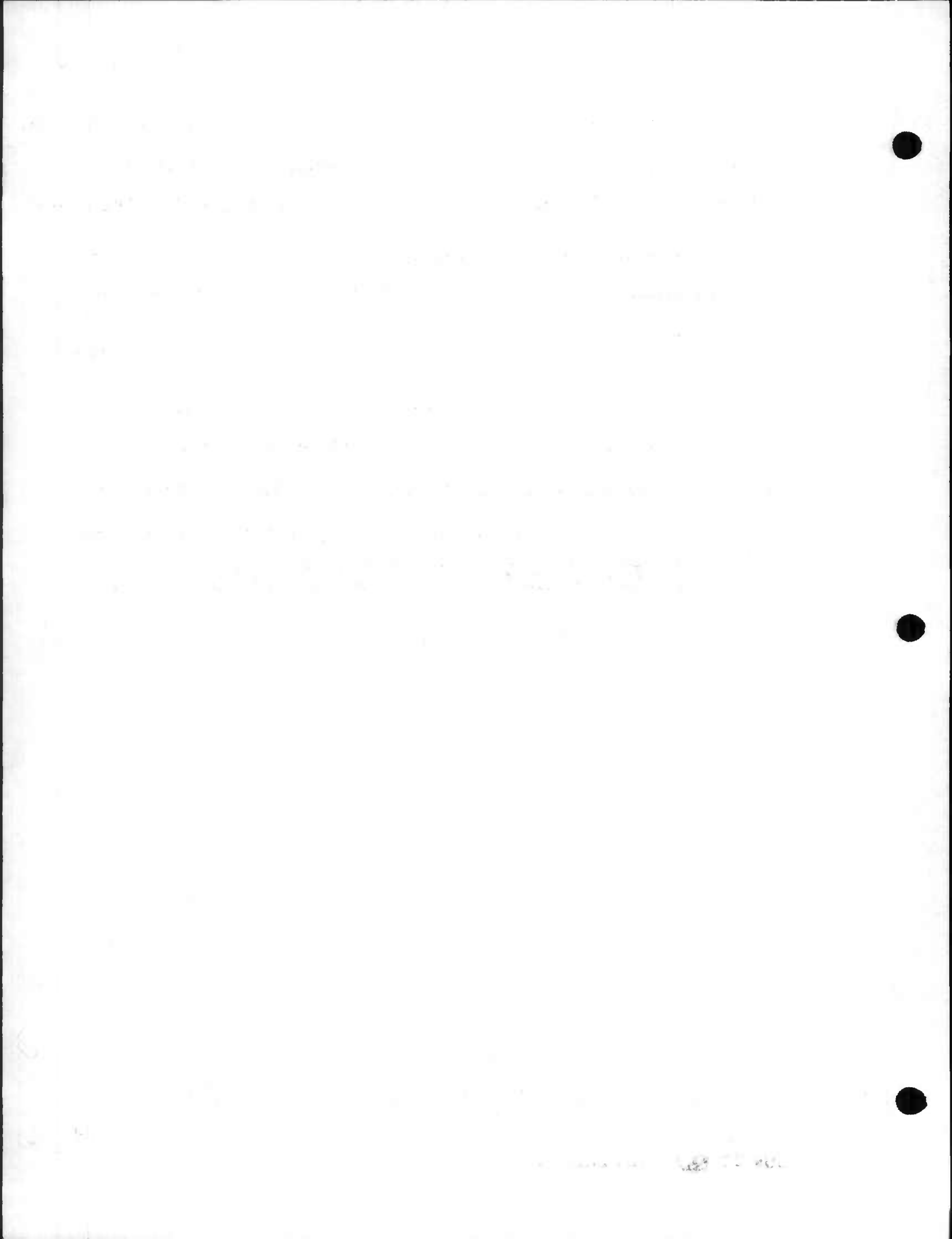
Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Doris E. Johnson				2. Date of Death Month June Day 23 , Year 1997		3. Time of Death 8:11 P.M.	
	4a. Facility Name (If not institution, give street and number) 6009 State Street				4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 577-66-6109		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 55 Yrs.		8. Date of Birth (Month, Day, Year) July 2, 1941	
	9. Birthplace (State or Foreign Country) Washington, D.C.		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Cheverly	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 6009 State Street		10f. Zip Code 20785		10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Private			
	17. Father's Name (First, Middle, Last) Leon Hollins, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Elezabeth Roberson			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Sylvester Hinnant Johnson - Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6009 State Street, Cheverly, Maryland 20785			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery		20c. Location - City or Town, State 6/28/97 Brentwood, Maryland		20d. Date	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee John T. Stewart III				22. Name and Address of Facility STEWART FUNERAL HOME, Inc. 4001 Benning Road, N.E., Washington, D.C.			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Breast Cancer Due to (or as a consequence of): e. Breast Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 13 months			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and Title of Certifier Harvey K. Miller MD				29c. License number D20352		29d. Date signed (Month, Day, Year) 6/24/97	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Harvey K. Miller MD 8926 Woodyard Rd. Clinton, MD							
To Be Completed by Physician/Medical Examiner	31. Date of Death (Month, Day, Year) JUN 27 1997				32. Registrar's Signature John D. [Signature]			
	33. Registrar's Name John D. [Signature]							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21056

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) LEE A. JOHNSON				2. Date of Death Month JUNE Day 24 Year 1997 <i>FOUND</i>		3. Time of Death 05:35 PM <i>FOUND</i>	
4a. Facility Name (If not institution, give street and number) 14600 OLD STAGE ROAD				4b. City, Town, or Location of Death BOWIE		4c. County of Death PRINCE GEORGES	
5. Social Security Number 214-58-0181		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 48 Yrs.		8. Date of Birth (Month, Day, Year) 12-25-48	
9. Birthplace (State or Foreign Country) Washington DC							
Usual Residence of Decedent							
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Bowie		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 14600 Old Stage Road				10f. Zip Code 20715		10g. Citizen of What Country? USA	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Horseman		16b. Kind of Business/Industry Private	
17. Father's Name (First, Middle, Last) Norman Paul Johnson				18. Mother's Name (First, Middle, Maiden Surname) Coline Beatrice Diggs			
19a. Informant's Name/Relationship (Type, Print) Paul Johnson/Brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14600 Old Stage Road, Bowie, Maryland 20715			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park		20c. Location - City or Town, State Landover, Maryland		20d. Date 06/30 1997	
21. Signature of Funeral Service Licensee Nancy A. Perante				22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Road, Landover, Maryland 20785			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CHRONIC RENAL FAILURE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ETHANOL ABUSE, CHRONIC							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier [Signature] MDE				29c. License number D33954		29d. Date signed (Month, Day, Year) JUNE 25, 1997	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MARIO F. GORUS JR MD, 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785							
31. Date filed (Month, Day, Year) JUN 27 1997				32. Registrar's Signature [Signature]			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21057

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edith Bernardine Knott				2. Date of Death Month Day Year June 22 1997		3. Time of Death 3:37 AM	
	4a. Facility Name (If not institution, give street and number) St. Mary's Hospital				4b. City, Town, or Location of Death Leonardtwn		4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 216-16-0113	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 6, 1923		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State MD		10b. County St. Mary's		10c. City, Town or Location Hollywood			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 25180 Sotterly Road				10f. Zip Code 20636		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bank Teller			16b. Kind of Business/Industry Bank	
17. Father's Name (First, Middle, Last) William Archie Pilkerton, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Helen Mae Wood				
19a. Informant's Name/Relationship (Type, Print) Joseph Edward Knott Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25180 Sotterly Rd., Hollywood, MD 20636				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. John's Cemetery		Date 6/26/97		20c. Location - City or Town, State Hollywood, MD		
21. Signature of Funeral Service Licensee <i>Michael L. Gardiner</i>				22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Acute myocardial infarction Due to (or as a consequence of): c. Dementia Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death one week one week
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and Title of certifier <i>Dr. M. A. Rahman, MD</i>		29c. License number D50044		29d. Date signed (Month, Day, Year) 06/24/97				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mohammad Rahman Leonardtown, MD 20650								
31. Date filed (Month, Day, Year) JUN 25 1997		32. Registrar's Signature <i>John A. Anderson-Randall</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be dated for use as the burial-transit

To Be Completed by Funeral Director


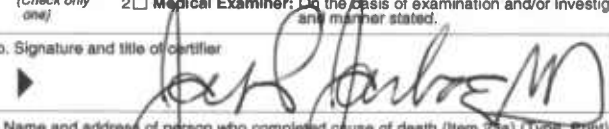
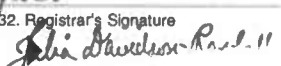
Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 21058**
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William Isaac Keffer				2. Date of Death Month June Day 5 Year 1997		3. Time of Death 2:55 PM	
	4a. Facility Name (If not institution, give street and number) 24316 Mervill Dean Road				4b. City, Town, or Location of Death Hollywood		4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 179-24-5857		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) Feb 29, 1924	
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Hollywood	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 24316 Mervill Dean Road		10f. Zip Code 20636		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1941-1962		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) 12th Grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Aviation Jet Mechanic		16b. Kind of Business/Industry U.S. Navy			
	17. Father's Name (First, Middle, Last) Joel S. Keffer		18. Mother's Name (First, Middle, Maiden Summa) Ellen Pearl Huey		19a. Informant's Name/Relationship (Type, Print) Dorothy R. Keffer/Spouse		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24316 Mervill Dean Rd., Hollywood, MD 20636	
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date 6/9/97		20c. Location - City or Town, State Alexandria, VA	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Carcinomatous Due to (or as a consequence of): b. Lung Cancer Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death months yr	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. C.O.P.D.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? N.A.	
	Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how Injury occurred						
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D 06419		29d. Date signed (Month, Day, Year) 6-6-97	
	30. Name and address of person who completed cause of death (Item 25a) (Type, Print) J. Patrick Jarboe, M.D.		Leonardtown, MD 20650					
	31. Date filed (Month, Day, Year) JUN 09 1997		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21059

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Grace Keleti				2. Date of Death Month Day Year June 24, 1997		3. Time of Death 8:07 a.m.			
	4a. Facility Name (If not institution, give street and number) 6003 84th Avenue				4b. City, Town, or Location of Death New Carrollton		4c. County of Death Prince George's			
Funeral Director	5. Social Security Number 215-34-7695		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 63 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 17, 1933		9. Birthplace (State or Foreign Country) North Carolina	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location New Carrollton				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 6003 84th Avenue				10f. Zip Code 20784		10g. Citizen of What Country? U.S.A.				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: American Indian			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) McKinley Locklear					18. Mother's Name (First, Middle, Maiden Surname) Sallie Hall					
19a. Informant's Name/Relationship (Type, Print) Stephen L. Keleti - Spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6003 84th Avenue, New Carrollton, Maryland 20784						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery		Data 06/27/97		20c. Location - City or Town, State Clinton, Maryland				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Aspiration Due to (or as a consequence of): c. Hypoxic Encephalopathy Due to (or as a consequence of): d. Ischemic Heart Disease Due to (or as a consequence of): Approximate Interval Between Onset and Death Days Days 2 Days Years										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D22780		29d. Date signed (Month, Day, Year) June 25, 1997				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter M. Schissler, M.D. 7500 Greenway Center Drive #430, Greenbelt, Maryland										
31. Date filed (Month, Day, Year) JUN 27 1997				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

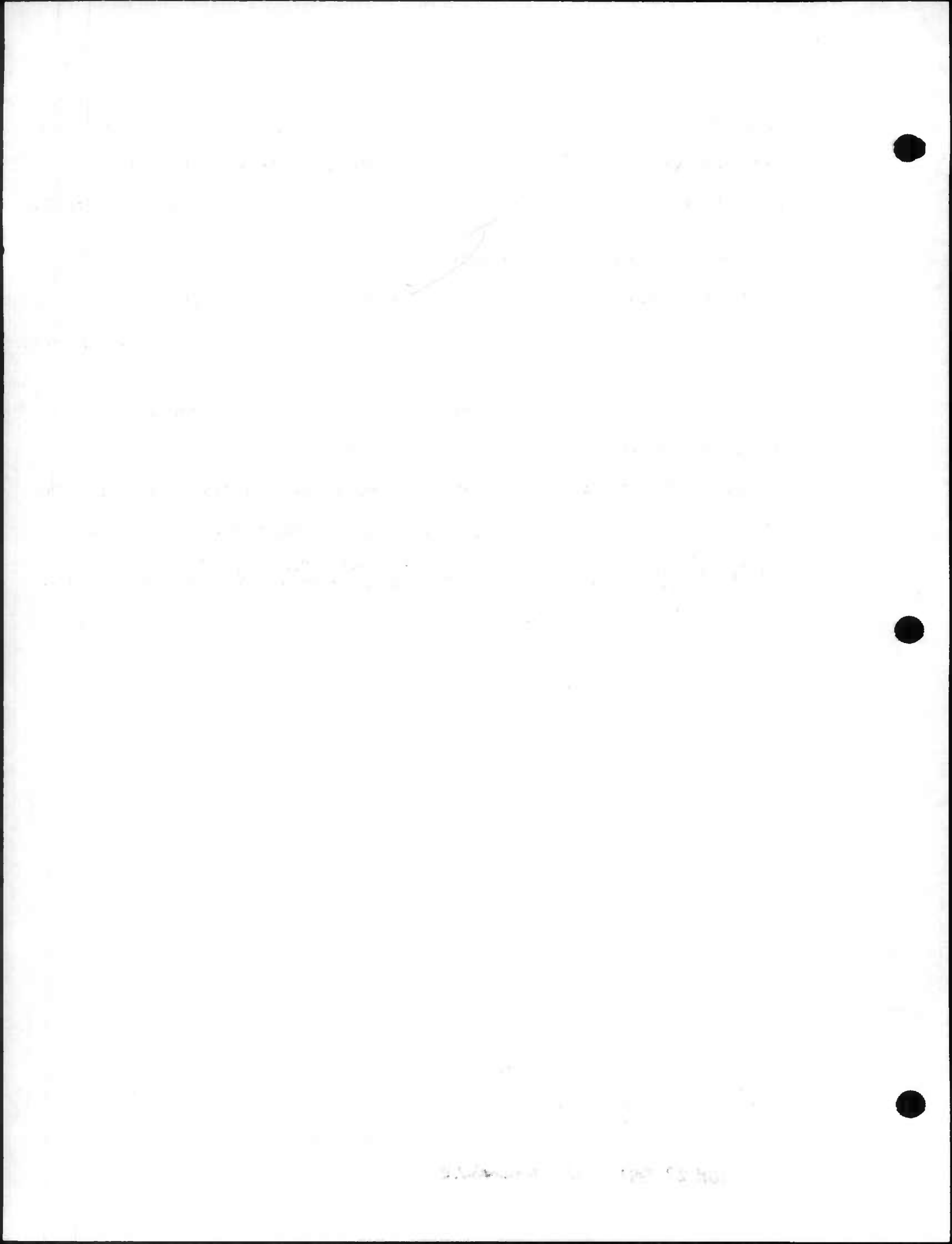
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21060

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Virginia M. Kay

2. Date of Death

Month Day Year
June 20, 1997

3. Time of Death

5:30 A.M.

4a. Facility Name (If not institution, give street and number)

Magnolia Gardens Nursing Home

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

324 30 0729

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
April 15, 1915

9. Birthplace (State or Foreign Country)

Illinois

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Glenn Dale

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

12016 Augusta Drive

10f. Zip Code

20769

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Harry Hero

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude Johnson

19a. Informant's Name/Relationship (Type, Print)

Harry G. Kay Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12016 Augusta Drive Glenn Dale Maryland 20769

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State☒ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

Metropolitan Crematory June 21, 1997 Alexandria Virginia

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Robert E. Evans Funeral Home, Inc.

16000 Annapolis Rd. Bowie Md. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 mo

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending Investigation☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D35820

29d. Date signed (Month, Day, Year)

6/20/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter Eckberg MD 14300 Gallant Fox Lane #110 Bowie, MD

31. Date filed (Month, Day, Year)

JUN 24 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Handwritten text, possibly a signature or date, located in the middle of the page.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21061
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Debra Jean Kraus

2. Date of Death

Month Day Year
JUNE 21, 1997

3. Time of Death

2:17AM

4a. Facility Name (If not institution, give street and number)

MARYLAND RTE# 32 1/2

4b. City, Town, or Location of Death

SYKESVILLE

4c. County of Death

CARROLL

Funeral
Director

5. Social Security Number

214-84-5103

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

35 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 7, 1962

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Sykesville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4227 Jim Bowers Road

10f. Zip Code

21784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

Henry Edward Kraus, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Catherine O. Malone

19a. Informant's Name/Relationship (Type, Print)

Mr. Henry Kraus, Jr. (Father)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

990 Eckard Court, Westminster, MD 21158

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadow Branch Cemetery

Date

6/24/97

20c. Location - City or Town, State

Westminster, MD

21. Signature of Funeral Service Licensee

Brian D. Hight

22. Name and Address of Facility

HAIGHT FUNERAL HOME & CHAPEL (Box 195)
Sykesville, MD 21784 (410)-795-1400

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Multiple Injuries

e. Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) SCENE

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation
2 ☒ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

6-21-97

28b. Time of Injury

2:17A

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

motor vehicle accident

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

street

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Rt. 32 Sykesville, Carroll Co., MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Douglas E. Wright MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JUNE 21, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dennis J. Chute, M.D. 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

JUN 25 1997

32. Registrar's Signature

Julia M. Radtke

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21062

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth Ann Kelly

2. Date of Death

Month Day Year

July 1 1997

3. Time of Death

2 AM

4a. Facility Name (If not institution, give street and number)

Genesis Eldercare Center

4b. City, Town, or Location of Death

LaPlata

4c. County of Death

Charles

Funeral
Director

5. Social Security Number

043-24-5653

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 21 1931

9. Birthplace (State or Foreign Country)

CT.

Usual Residence of Decedent

10a. State

MD

10b. County

Charles

10c. City, Town or Location

Indian Head

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4 Fairmont Pl.

10f. Zip Code

20640

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Waitress

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Clifford Hedin

18. Mother's Name (First, Middle, Maiden Surname)

Mary Bukavsky Hedin

19a. Informant's Name/Relationship (Type, Print)

Claire Dawson/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 265 Ironsides, MD 20643

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crem.

Data

7/1/97

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

David C. Echols

MO0945

22. Name and Address of Facility

AREHART-ECHOLS FUNERAL HOME, INC.

P.O. Box 567 LaPlata, MD 20646

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Cancer of Lung, Metastatic

Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

G. P. ...

29c. License number

D20629

29d. Date signed (Month, Day, Year)

7/2/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

G. P. ...

31. Date filed (Month, Day, Year)

JUL 02 1997

32. Registrar's Signature

Julia ...

State
RegistrarElizabeth Kelly
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21063

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Evelyn Gloria Keplinger Langrall

2. Date of Death

June 29^{Day} 1997^{Year}

3. Time of Death

4:45PM

4a. Facility Name (If not institution, give street and number)

Memorial Hospital

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral
Director

5. Social Security Number

218-20-9008

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 30, 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Caroline

10c. City, Town or Location

Greensboro

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

Maple Avenue

10f. Zip Code

21639

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Nurses Aide

16b. Kind of Business/Industry

Health Care

17. Father's Name (First, Middle, Last)

John Keplinger

18. Mother's Name (First, Middle, Maiden Surname)

Lydia Scherck

19a. Informant's Name/Relationship (Type, Print)

Suzette L. Lackey Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9016 Raven Drive Jonesboro, Georgia 30238

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dorchester Memorial Park

Date

7/3/97

20c. Location - City or Town, State

Cambridge, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Thomas Funeral Home, P.A.

700 Locust Street Cambridge, Maryland 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular accident

Due to (or as a consequence of):

4 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Chronic obstructive pulmonary disease

Due to (or as a consequence of):

years

c. pneumonia

Due to (or as a consequence of):

3 weeks

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Bipolar Disorder

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

039749

29d. Date signed (Month, Day, Year)

6/30/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

D. Gregg Oliver, M.D. 503 Dutchman's Lane Easton, Maryland 21601

31. Date filed (Month, Day, Year)

JUL 2 1997

32. Registrar's Signature

John Andrew Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

21064

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Baby Boy Revels Byron Lamont Landrum

2. Date of Death

Month Day Year
June 16 1997

3. Time of Death

808 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

6. Sex

1 ☒ M 2 ☐ F

7. Age (In Yrs. last birthday)

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
06-14-97

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Pocomoke

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

515 Laurel St.

10f. Zip Code

21851

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary or Secondary (0-12)

N/A

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

HENRY Lamont Landrum

18. Mother's Name (First, Middle, Maiden Surname)

Timika Lee Revels

19a. Informant's Name/Relationship (Type, Print)

Timika Lee Revel/mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

515 Laurel St. Pocomoke City, MD 21851

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

MT. Zion Cemetery

Date

6-24-97

20c. Location - City or Town, State

Pocomoke City, MD

21. Signature of Funeral Service Licensee

Anthony E. Ward

22. Name and Address of Facility

Anthony E. Ward Funeral Homes

30639 Hampden Ave. Princess Anne, MD 21853

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Septic Shock

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

8 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Presumed Bacterial Sepsis

Due to (or as a consequence of):

unknown

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Prematurity (30 weeks gestation)

respiratory distress syndrome

anemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Christiane Theda M.D.

29c. License number

D39805

29d. Date signed (Month, Day, Year)

June 16, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Christiane Theda M.D. Dept. of Neonatology

Johns Hopkins Bayview Medical Center 4940 Eastern Ave, Baltimore Md 21224

31. Date filed (Month, Day, Year)

JUN 19 1997

32. Registrar's Signature

Julia Bruckner Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

THE UNIVERSITY OF CHICAGO

LIBRARY

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21065

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RUTH ELIZABETH LEONARD				2. Date of Death Month Day Year June 18 1997		3. Time of Death 1:55 PM.																																
	4e. Facility Name (If not institution, give street and number) St. Mary's Hospital				4b. City, Town, or Location of Death Leonardtown		4c. County of Death St. Mary's																																
Funeral Director	5. Social Security Number 214-20-5512		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) September 16, 1925																																
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location California																																
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number P.O. Box 316		10f. Zip Code 20619		10g. Citizen of What Country? United States																																
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White																																
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry N/A																																		
	17. Father's Name (First, Middle, Last) William John Schmelyun				18. Mother's Name (First, Middle, Maiden Surname) Katherine Marie Schaefer																																		
	19e. Informant's Name/Relationship (Type, Print) Ronald L. Leonard Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 316, California, Maryland 20619																																		
	20e. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date 6/19/97		20c. Location - City or Town, State Alexandria, Virginia																																
	21. Signature of Funeral Service Licensee Edward N. Brinsfield, Jr. M00052		22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, Maryland 20650																																				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																						
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. CATHERIA</td> <td rowspan="4">Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death 1 yr</td> </tr> <tr> <td>b. OVARIAN CANCER</td> </tr> <tr> <td>c.</td> </tr> <tr> <td>d.</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. CATHERIA	Due to (or as a consequence of):	Approximate Interval Between Onset and Death 1 yr	b. OVARIAN CANCER	c.	d.																								
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c.																																							
d.																																							
<table border="1"> <tr> <td colspan="4">23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</td> </tr> <tr> <td colspan="2">24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> <td colspan="2">24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> </tr> </table>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																									
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<table border="1"> <tr> <td colspan="4">25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> <td colspan="4">26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</td> </tr> <tr> <td colspan="2">27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined</td> <td colspan="2">28e. Date of Injury (Month, Day Year)</td> <td colspan="2">28b. Time of Injury M</td> <td colspan="2">28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> </tr> <tr> <td colspan="4">28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</td> <td colspan="4">28d. Describe how injury occurred</td> </tr> <tr> <td colspan="4">28f. Location (Street and Number or Rural Route Number, City or Town, State)</td> <td colspan="4"></td> </tr> </table>								25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
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29b. Signature and title of certifier 		29c. License number D34537		29d. Date signed (Month, Day, Year) 6. 19. 97																																			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KHALID HUSAIN M.D. BRENTON MEDICAL GROUP CALIFORNIA MD. 20619																																							
31. Date filed (Month, Day, Year) JUN 19 1997				32. Registrar's Signature 																																			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

RUTH ELIZABETH LEONARDTOWN

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

20

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 21066

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James Melvin Long				2. Date of Death Month Day Year May 27, 1997		3. Time of Death 5:00 P.M.	
	4a. Facility Name (If not institution, give street and number) St. Mary's Hospital				4b. City, Town, or Location of Death Leonardtwn		4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 577-09-2581		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 25, 1916	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Mechanicsville			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 27215 Three Notch Road				10f. Zip Code 20659		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th Grade College (1-4 or 5+) College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cab Driver		16b. Kind of Business/Industry Cab Company	
	17. Father's Name (First, Middle, Last) Joseph Albert Long				18. Mother's Name (First, Middle, Maiden Surname) Anna V. Brightley			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Etoyle B. Long/Spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27215 Three Notch Road, Mechanicsville, MD 20659			
	20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Charles Memorial Gardens		Date 5/30/97		20c. Location - City or Town, State Leonardtwn, MD	
	21. Signature of Funeral Service Licensee Michael L. Budiner				22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MULTICENTRIC CARCINOMA Due to (or as a consequence of): b. Of Small Intestine with Due to (or as a consequence of): c. metastasis Due to (or as a consequence of): d. Anemia Approximate Interval Between Onset and Death 4 weeks 4 Wks							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				28b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Adinath A. Patil, M.D.			
State Registrar	29c. License number D23634				29d. Date signed (Month, Day, Year) May 30, 1997			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Adinath A. Patil, M.D. Leonardtown, MD 20650							
31. Date filed (Month, Day, Year) JUN 02 1997				32. Registrar's Signature John Davidson-Randall				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21067

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) <i>Cindy L Lewis</i>				2. Date of Death Month <i>8</i> Day <i>6</i> Year <i>97</i>		3. Time of Death <i>9:16 AM</i>	
4a. Facility Name (If not institution, give street and number) <i>R.A. Cowley Shock Trauma Center</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>Baltimore</i>	
5. Social Security Number <i>545-25-7200</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>39</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>July 26, 1957</i>	
9. Birthplace (State or Foreign Country) <i>California</i>							

Funeral
Director

To Be Completed by Funeral Director

Usual Residence of Decedent		10a. State <i>Maryland</i>		10b. County <i>Calvert</i>		10c. City, Town or Location <i>Owings</i>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <i>Simpson Farm Road, 8791</i>				10f. Zip Code <i>20736</i>		10g. Citizen of What Country? <i>United States</i>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>1976-1979</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Security Specialist</i>		16b. Kind of Business/Industry <i>U.S. Defense</i>			
17. Father's Name (First, Middle, Last) <i>Harvey Lee Lewis</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Wanda Blackwell</i>					
19a. Informant's Name/Relationship (Type, Print) <i>Jason Robert Babcock, Son</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>25036 Pinto Drive, Hollywood, Maryland 20636</i>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Metropolitan Crematory</i>		Date <i>6-9-97</i>		20c. Location - City or Town, State <i>Alexandria, Virginia</i>			
21. Signature of Funeral Service Licensee <i>Edward N. Brinsfield, Jr.</i>				22. Name and Address of Facility <i>Brinsfield Funeral Home P.A. 22955 Hollywood Road, Leonardtown, Maryland 20650-0279</i>					

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. <i>BRAIN DEATH</i> Due to (or as a consequence of): b. <i>BRAIN Herniation</i> Due to (or as a consequence of): c. <i>Cerebral Edema</i> Due to (or as a consequence of): d. <i>Carbon Monoxide Poisoning</i>				Approximate Interval Between Onset and Death <i>-0- 1/2 hr 1/2 hr 23 hrs</i>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Depression</i>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <i>6/5/97</i>		28b. Time of Injury <i>10:00 AM</i>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <i>Vehicle Running in Garage</i>		28e. Location (Street and Number or Rural Route Number, City or Town, State) <i>8791 Simpson Farm Road</i>	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>A. Neal Reynolds</i>		29c. License number <i>D 27163</i>	
29d. Date signed (Month, Day, Year) <i>6/6/97</i>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>R.A. Cowley Shock Trauma Center, 22 S. Greene St. Baltimore Md 21201</i>			
31. Date filed (Month, Day, Year) <i>JUN 09 1997</i>		32. Registrar's Signature <i>Johanna Anderson Randall</i>			

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21068

Item:5 per FH G-749 7/10/97 dh

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GERTRUDE A MOLSTER		2. Date of Death Month July Day 02 Year 1997		3. Time of Death 1908
	4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL		4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY
Funeral Director	5. Social Security Number 578-60-9308 677-10-9393	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) SEPT. 3, 1906		9. Birthplace (State or Foreign Country) OHIO		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State MD.	10b. County MONTGOMERY	10c. City, Town or Location MONTGOMERY VILLAGE		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 8313 FRONTWELL CIRCLE		10f. Zip Code 20879		10g. Citizen of What Country? UNITED STATES
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry OWN HOME		
	17. Father's Name (First, Middle, Last) SELDEN W. ANDERSON		18. Mother's Name (First, Middle, Maiden Surname) GERTRUDE G. BURD		
	19a. Informant's Name/Relationship (Type, Print) WILLIAM A. MOLSTER, SON		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8313 FRONTWELL CIRCLE, MONTGOMERY VILLAGE, MD. 20879		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) METROPOLITAN CREMATORY		20c. Location - City or Town, State 7/3/97 ALEXANDRIA, VIRGINIA
	21. Signature of Funeral Service Licensee <i>Muriel H. Barber</i>		22. Name and Address of Facility MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) Right Emphysema				UNKNOWN
	Due to (or as a consequence of): Pneumonia				6 WEEKS
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Sepsis Hypotension BRADY CARDIA					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <i>Barry J. Levin, MD</i>		29c. License number 20562		29d. Date signed (Month, Day, Year) July 02, 1997	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barry J. Levin, MD 10215 Fernwood Road Bethesda, MD.					
31. Date filed (Month, Day, Year) JUL 10 1997		32. Registrar's Signature <i>Julia Davidson-Randall</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Certificate of Death

Reg. No.

21069

Physician / Medical Examiner

Funeral Director

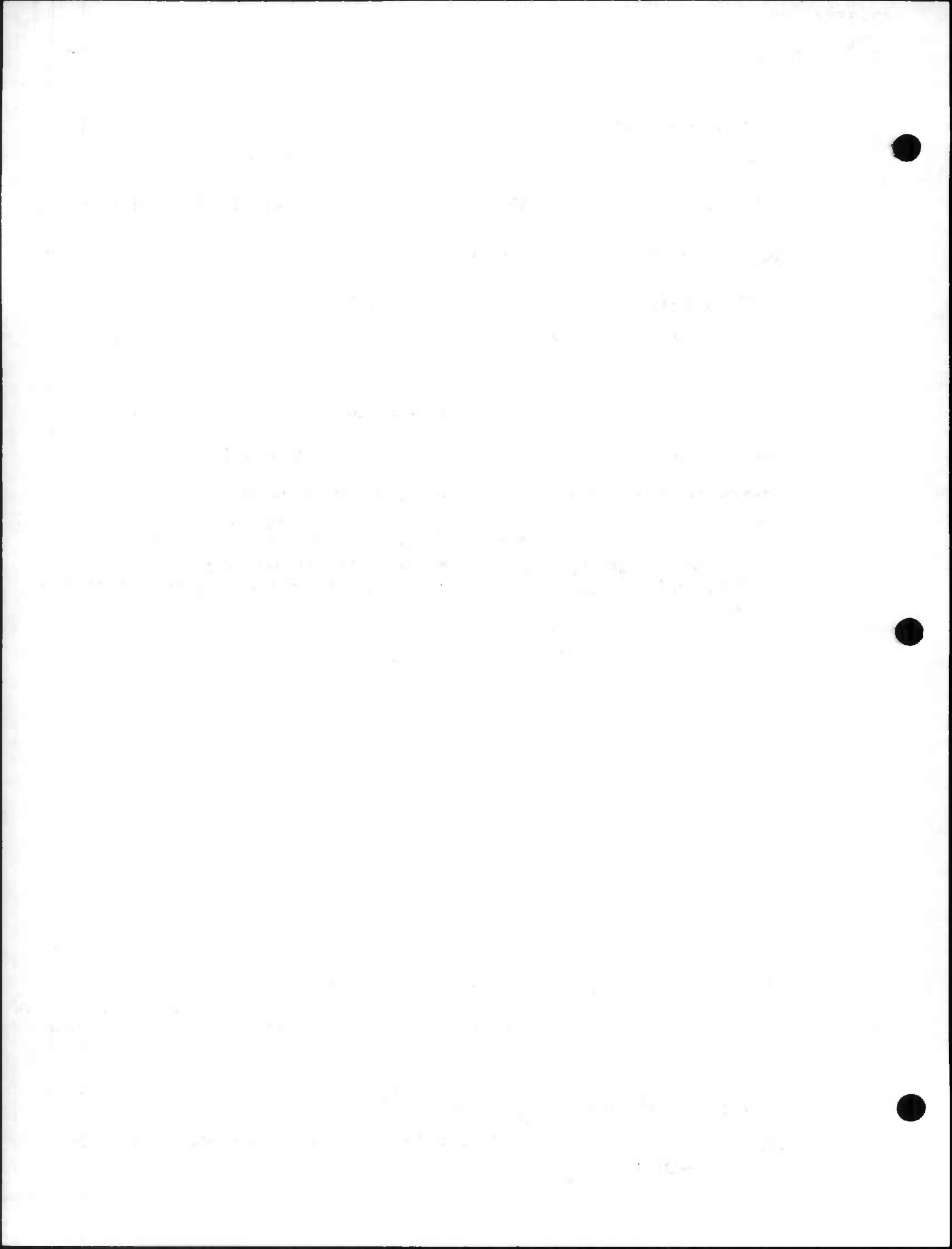
Physician / Medical Examiner

State Registrar

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Carl J. Melone, Jr.				2. Date of Death Month Day Year JUNE 26, 1997				3. Time of Death 0835 AM	
4a. Facility Name (If not institution, give street and number) I-95				4b. City, Town, or Location of Death HAVRE DE GRACE				4c. County of Death HARFORD	
5. Social Security Number 205-36-1144		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 48 Yrs.		8. Date of Birth (Month, Day, Year) July 18, 1948		9. Birthplace (State or Foreign Country) Philadelphia, PA	
10a. State PA		10b. County Chester		10c. City, Town or Location Malvern				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 25 Theresa Dr.				10f. Zip Code 19355				10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Financial Executive				16b. Kind of Business/Industry Financial	
17. Father's Name (First, Middle, Last) Carl J. Melone				18. Mother's Name (First, Middle, Maiden Surname) Claire Switaj					
19a. Informant's Name/Relationship (Type, Print) Barbara K. Melone/ Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25 Theresa Dr., Malvern, PA 19355					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Philadelphia Memorial Pk.		Date June 30, 1997		20c. Location - City or Town, State Frazer, PA			
21. Signature of Funeral Service Licensee <i>Richard L. Joffe</i>				22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 111 S. Queen St., Box 248, Rising Sun, MD 21911					
23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) ROADWAY					
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 6-26-97		28b. Time of Injury 0627 M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Subject struck by truck Interstate 95 south Harford County, Maryland	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>Stephen S. Radentz, MD</i>				29c. License number O.C.M.E	
				29d. Date signed (Month, Day, Year) JUNE 27, 1997					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) JUN 30 1997				32. Registrar's Signature <i>J. Davidson-Randall</i>					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21070

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lillian G. Miller

2. Date of Death

Month Day Year
JUNE 23 1997 12:20 PM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Union Hospital

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

5. Social Security Number

194-46-5223

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

43 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Dec. 19, 1953

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Pa.

10b. County

Chester

10c. City, Town or Location

Elverson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3641 Saint Peters Road

10f. Zip Code

19520

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Registered Nurse

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

Daniel Gelok

18. Mother's Name (First, Middle, Maiden Surname)

Evelyn Nicholas

19a. Informant's Name/Relationship (Type, Print)

Daniel Gelok, Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Rte. 57 Port Murray, N.J. 07865

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

H. G. Smith Crematory 6/27/97 Stroudsburg, Pa.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

259 E. MAIN St,
Gee Funeral Home Elkton, Md. 21921

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Acute Inferior MI

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pancytopenia

Lactic Acidosis

Coagulopathy

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Christopher A. Bowen MD

29c. License number

C10002916

29d. Date signed (Month, Day, Year)

6/23/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Delaware Heart Group Medical Arts Pavilion Newark De 19713

31. Date filed (Month, Day, Year)

JUN 25 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

MILLER, LILLIAN G.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

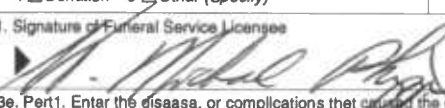

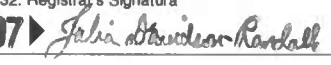
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97 21071

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Bridget Frances McCracken						2. Date of Death Month June Day 25 Year 1997		3. Time of Death 6:20 am																		
	4a. Facility Name (If not institution, give street and number) Solomons Nursing Center						4b. City, Town, or Location of Death Solomons		4c. County of Death Calvert																		
Funeral Director	5. Social Security Number 242 20 0154		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) July 28, 1920		9. Birthplace (State or Foreign Country) NC																		
	Usual Residence of Decedent																										
10a. State MD		10b. County Calvert		10c. City, Town or Location Port Republic				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																			
10e. Street and Number 3380 Howard Drive				10f. Zip Code 20676		10g. Citizen of What Country? USA																					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white																			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4or 5+) College (1-4or 5+)				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) house wife			16b. Kind of Business/Industry own home																				
17. Father's Name (First, Middle, Last) Delas C Reece						18. Mother's Name (First, Middle, Maiden Surname) Bertha Burke																					
19a. Informant's Name/Relationship (Type, Print) M. Frank McCracken/ son						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as 10 above																					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Morning Star Cemetery		Data 6-28-97		20c. Location - City or Town, State Canton, NC																			
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Rausch Funeral Home, Owings, MD 20736																					
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																											
<table border="0" style="width:100%;"> <tr> <td style="width:30%;"> Immediate Cause (Final disease or condition resulting in death) Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td style="width:60%;"> <table border="0"> <tr> <td>a. RESPIRATORY FAILURE</td> <td rowspan="4" style="width:10%; vertical-align: middle; font-size: 4em;">}</td> <td rowspan="4" style="width:20%; vertical-align: middle;">2-3 yrs.</td> </tr> <tr> <td>b. SEVERE CHRONIC OBSTRUCTIVE Pul. DISEASE</td> </tr> <tr> <td>c. _____</td> </tr> <tr> <td>d. _____</td> </tr> </table> </td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death) Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<table border="0"> <tr> <td>a. RESPIRATORY FAILURE</td> <td rowspan="4" style="width:10%; vertical-align: middle; font-size: 4em;">}</td> <td rowspan="4" style="width:20%; vertical-align: middle;">2-3 yrs.</td> </tr> <tr> <td>b. SEVERE CHRONIC OBSTRUCTIVE Pul. DISEASE</td> </tr> <tr> <td>c. _____</td> </tr> <tr> <td>d. _____</td> </tr> </table>	a. RESPIRATORY FAILURE	}	2-3 yrs.	b. SEVERE CHRONIC OBSTRUCTIVE Pul. DISEASE	c. _____	d. _____										
Immediate Cause (Final disease or condition resulting in death) Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<table border="0"> <tr> <td>a. RESPIRATORY FAILURE</td> <td rowspan="4" style="width:10%; vertical-align: middle; font-size: 4em;">}</td> <td rowspan="4" style="width:20%; vertical-align: middle;">2-3 yrs.</td> </tr> <tr> <td>b. SEVERE CHRONIC OBSTRUCTIVE Pul. DISEASE</td> </tr> <tr> <td>c. _____</td> </tr> <tr> <td>d. _____</td> </tr> </table>	a. RESPIRATORY FAILURE	}	2-3 yrs.	b. SEVERE CHRONIC OBSTRUCTIVE Pul. DISEASE	c. _____	d. _____																				
a. RESPIRATORY FAILURE	}	2-3 yrs.																									
b. SEVERE CHRONIC OBSTRUCTIVE Pul. DISEASE																											
c. _____																											
d. _____																											
<table border="0" style="width:100%;"> <tr> <td style="width:70%;"> Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Alzheimer's Disease Coronary Artery Disease </td> <td style="width:30%;"> 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No </td> </tr> </table>										Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Alzheimer's Disease Coronary Artery Disease	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Alzheimer's Disease Coronary Artery Disease	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																										
<table border="0" style="width:100%;"> <tr> <td style="width:30%;"> 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No </td> <td colspan="7"> 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) </td> </tr> <tr> <td> 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined </td> <td> 28a. Date of Injury (Month, Day, Year) </td> <td> 28b. Time of Injury M </td> <td> 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No </td> <td colspan="6"> 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) </td> </tr> </table>										25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)					
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29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																											
29b. Signature and title of certifier  MD				29c. License number D50249		29d. Date signed (Month, Day, Year) 6/25/97																					
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) 110 HOSP DR, #303, PR. FREDERICK, MD 20678																											
31. Date filed (Month, Day, Year) JUN 27 1997				32. Registrar's Signature 																							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

**State
Registrar**

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21072

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Alvin Mattingly				2. Date of Death Month Day Year June 2, 1997		3. Time of Death 3:58 P.M.	
	4a. Facility Name (If not institution, give street and number) St. Mary's Hospital				4b. City, Town, or Location of Death Leonardtwn		4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 215-02-1100		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 28 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 6, 1968	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County St. Mary's	10c. City, Town or Location Leonardtwn			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 22803 Pope Street			10f. Zip Code 20650		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 9th Grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Auto Mechanic		16b. Kind of Business/Industry Tire Company			
	17. Father's Name (First, Middle, Last) James Latham Mattingly, Sr.				18. Mother's Name (First, Middle, Maiden Summa) Hazel Beatrice Toute			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Lydia E. Mattingly/Spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22803 Pope Street, Leonardtown, MD 20650			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Charles Memorial Gardens		Date 6-06-97	20c. Location - City or Town, State Leonardtwn, MD		
	21. Signature of Funeral Service Licensee <i>Michael R. Gardiner</i>				22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>GSW-Head Suicide</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 6-2-97		28b. Time of Injury 3:58 P.M.		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred GSW
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>William D. Boyd, II, M.D.</i>		29c. License number D14285		29d. Date signed (Month, Day, Year) 6-3-97		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) William D. Boyd, II, M.D. Leonardtown, Maryland 20650								
31. Date filed (Month, Day, Year) JUN 04 1997		32. Registrar's Signature <i>John Davidson Randall</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

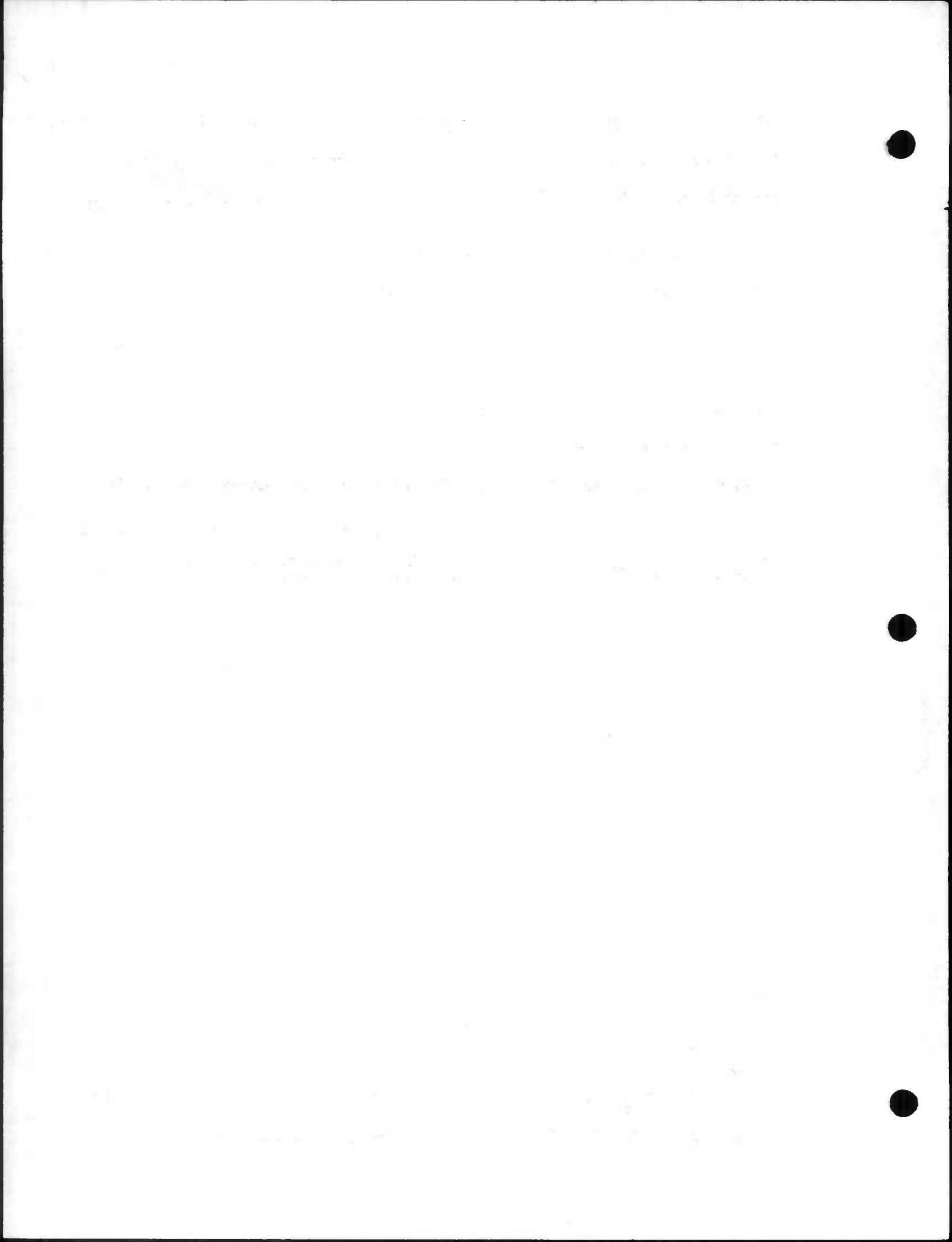
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21073

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles Henry Mason, Sr.				2. Date of Death Month Day Year June 2 1997		3. Time of Death 12:15 PM	
	4a. Facility Name (If not institution, give street and number) St. Mary's Hospital				4b. City, Town, or Location of Death Leonardtown		4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 225-10-2386		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) December 26, 1910	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Tall Timbers	
To Be Completed by Funeral Director	10d. Inside City Limits 1 Yes 2 No		10e. Street and Number 18 River Road		10f. Zip Code 20690		10g. Citizen of What Country? United States	
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Postmaster		16b. Kind of Business/Industry U.S. Postal Service			
	17. Father's Name (First, Middle, Last) Emmett Mason				18. Mother's Name (First, Middle, Maiden Surname) Mary McCormack			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Charles H. Mason, Jr. Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18 River Road, Tall Timbers, Maryland 20690			
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. George Catholic Cemetery		Data 6/6/97		20c. Location - City or Town, State Valley Lee, Maryland	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Director Edward N. Brinsfield, Jr. MO0052				22. Name and Address of Facility Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Auto non quiver myocardial Due to (or as a consequence of): Defection 2 to 4 days coronary artery disease years Due to (or as a consequence of): 1 Congestive Heart Failure 2 Chronic obstructive pulmonary disease							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Congestive Heart Failure 2 Chronic obstructive pulmonary disease				23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown			
	24a. Was an autopsy performed? 1 Yes 2 No				24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)					
	27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day, Year) June 2 1997		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier Kiran D. Mehta				29c. License number D36206		29d. Date signed (Month, Day, Year) 06/05/97	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KIRAN D. MEHTA, M.D. PO Box 664 LEONARDTOWN, MD 20650							
State Registrar	31. Date filed (Month, Day, Year) JUN 6 1997				32. Registrar's Signature John Davidson-Randall			

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

CHARLES HENRY MASON

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21074

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM HAYDEN MORGAN, JR.						2. Date of Death Month Day Year June 16 1997			3. Time of Death 6:18 AM.						
	4a. Facility Name (If not institution, give street and number) St. Mary's Hospital						4b. City, Town, or Location of Death Leonardtown			4c. County of Death St. Mary						
Funeral Director	5. Social Security Number 215-36-5717		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 62 Yrs.		8. Date of Birth (Month, Day, Year) Nov 1, 1934		9. Birthplace (State or Foreign Country) MD							
	Usual Residence of Decedent															
To Be Completed by Funeral Director	10a. State MD		10b. County St. Mary		10c. City, Town or Location Mechanicville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	10e. Street and Number 40781 Parlett Morgan Rd.				10f. Zip Code 20659			10g. Citizen of What Country? USA								
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer				16b. Kind of Business/Industry Own Farm							
	17. Father's Name (First, Middle, Last) William Hayden Morgan, Sr.						18. Mother's Name (First, Middle, Maiden Surname) Catherine Matilda Hyde									
	19a. Informant's Name/Relationship (Type, Print) Dorothy L. Morgan/Wife						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40781 Parlett Morgan Rd., Mechanicville, MD 20659									
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Charles Memorial Gardens		Date 6/19/97		20c. Location - City or Town, State Leonardtown, MD							
	21. Signature of Funeral Service Licensee <i>Michael K. Gardiner</i>						22. Name and Address of Facility Matingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650									
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>Cardiorespiratory arrest</i> Due to (or as a consequence of): b. <i>Sepsis</i> Due to (or as a consequence of): c. <i>Oxygenated left leg</i> Due to (or as a consequence of): d. <i>Diabetes mellitus, peripheral vascular disease, chronic renal failure</i> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last											Approximate Interval Between Onset and Death 5 minutes 48 hrs 48 hrs years				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
											24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No											26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred						
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											29b. Signature and title of certifier <i>[Signature]</i>		29c. License number D29821		29d. Date signed (Month, Day, Year) 6/17/97	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAMES I. DAMALOUJI M.D. 650 MOAKLEY ST. LEONARDTOWN, MD. 20650																
31. Date filed (Month, Day, Year) JUN 18 1997											32. Registrar's Signature <i>John Andrew Randall</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

97-3485-013

CIP

HERMAN REISER MARTIN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21075

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Herman Reiser Martin				2. Date of Death Month Day Year JUNE 23, 1997		3. Time of Death 7:28 PM	
	4e. Facility Name (If not institution, give street and number) 604 BRENDA WAY				4b. City, Town, or Location of Death FINKSBURG		4c. County of Death CARROLL	
Funeral Director	5. Social Security Number 217-12-6693		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) July 26 1924	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Carroll		10c. City, Town or Location Westminster	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 604 Brenda Way		10f. Zip Code 21157		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
	15. Decedent's Education (Specify only highest grade completed) 12 Elementary/Secondary (0-12) Collega (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) office worker		16b. Kind of Business/Industry BGE			
	17. Father's Name (First, Middle, Last) Francis Augustus Martin				18. Mother's Name (First, Middle, Maiden Surname) Margaret Reiser 21228			
	19a. Informant's Name/Relationship (Type, Print) Imelda M. Kral, sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 715 Maiden Choice Lane Apt. CC413 Catonsville 21228			
	20e. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Entombment Gardens of Faith		20c. Location - City or Town, State Overlea, Maryland			
	21. Signature of Funeral Service Licensee Katharine Pritts - Switzer		22. Name and Address of Facility Pritts Funeral Home & Chapel 412 Washington Rd., Westminster, MD					
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred						
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier O.C.M.E.				29c. License number		29d. Date signed (Month, Day, Year) JUNE 24, 1997		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DAVID R. FOWLER M.D. 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) JUN 26 1997				32. Registrar's Signature John Andrew Randall				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21076

Certificate of Death

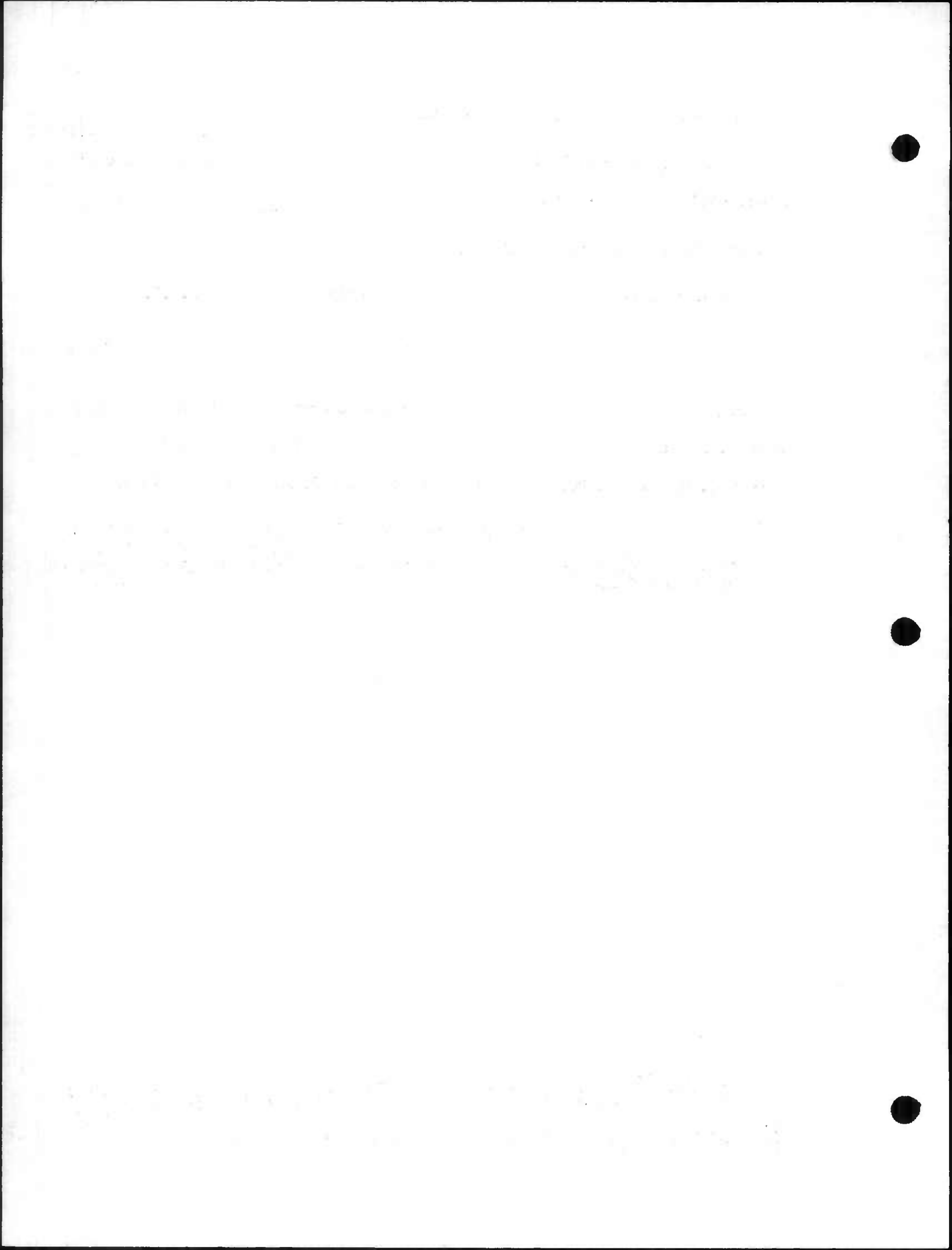
Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Florence M. McEachern				2. Date of Death Month Day Year June 28, 1997		3. Time of Death 11:15AM	
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital				4b. City, Town, or Location of Death Clinton		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 032-14-9954		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) June 2, 1911	
	9. Birthplace (State or Foreign Country) MA		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Clinton	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 8914 Ballard Lane		10f. Zip Code 20735		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrative Supervisor		16b. Kind of Business/Industry State Government			
	17. Father's Name (First, Middle, Last) John J. Scanlon		18. Mother's Name (First, Middle, Maiden Surname) Julia Dean		19a. Informant's Name/Relationship (Type, Print) Dorothy C. Hearon (Sister)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8914 Ballard Lane Clinton, Maryland 20735	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Trinity Memorial Gardens		20c. Location - City or Town, State Waldorf, Maryland		21. Signature of Funeral Service Licensee	
	22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton Maryland 20735		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PNEUMONIA Due to (or as a consequence of): b. URINARY TRACT INFECTION Due to (or as a consequence of): c. ATHEROSCLEROTIC HEART DISEASE Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 4 Days 4 Days			
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how Injury occurred 28e. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier R. B. Samant MD		29c. License number D27744		29d. Date signed (Month, Day, Year) 6.28.97	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR RAJ. SAMTANI MD 9131 PISCATAWAY RD, CLINTON		31. Date filed (Month, Day, Year) JUL 02 1997		32. Registrar's Signature John Andrew Randall			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21077

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARY Morrell		2. Date of Death Month June Day 21 Year 97		3. Time of Death 11:45 PM
	4a. Facility Name (If not institution, give street and number) HOLY CROSS HOSPITAL		4b. City, Town, or Location of Death SILVER SPRING		4c. County of Death MONTGOMERY
Funeral Director	5. Social Security Number 162-30-5291	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 60 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) APRIL 11, 37		9. Birthplace (State or Foreign Country) SOUTH CAROLINA		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State N/A	10b. County N/A	10c. City, Town or Location WASHINGTON, D.C.		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 1435 NEWTON ST. N.W.		10f. Zip Code 20010		10g. Citizen of What Country? UNITED STATES AMERICA
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th GRADE		18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SALES		16b. Kind of Business/Industry PRIVATE
	17. Father's Name (First, Middle, Last) JAMES LITTLES		18. Mother's Name (First, Middle, Maiden Surname) MAMMIE BYRD		
	19a. Informant's Name/Relationship (Type, Print) GEORGE H. MORRELL, JR.		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) APT. 104 1435 NEWTON ST. N.W. W.D.C. 20010		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HARMONY MEM. PK.		20c. Location - City or Town, State 6-27-97 LANDOVER, MD.
	21. Signature of Funeral Service Licensee <i>Belra Jenkins</i>		22. Name and Address of Facility JOHNSON & JENKINS INC. 716 KENNEDY ST. N.W. W.D.C. 20011		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
Immediate Cause (Final disease or condition resulting in death) e. CENTRAL NERVOUS system Sarcoidosis Due to (or as a consequence of): years b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day Year)					
28b. Time of Injury M					
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>John Tauber MD</i>					
29c. License number D08546					
29d. Date signed (Month, Day, Year) June 20 97					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) John Tauber 8218 Wisconsin Ave Bethesda Md.					
31. Date filed (Month, Day, Year) JUN 27 1997					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21078

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CLYDE

MINNICK

2. Date of Death

Month

Day

Year

JUNE

23

1997

3. Time of Death

4:20 PM

4a. Facility Name (If not institution, give street and number)

WASHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

578-42-8409

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

64

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Oct. 11, 1932

9. Birthplace (State or Foreign Country)

Edgefield, S.C.

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

District of Columbia

Washington

10e. Street and Number

1207 D Street, N. E.

10f. Zip Code

20002

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No 2/6/53

If Yes, Give Year or Dates: 2/5/57

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Hospital Worker

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Vannie Minnick

18. Mother's Name (First, Middle, Maiden Surname)

Lucy Butler

19a. Informant's Name/Relationship (Type, Print)

Lucy Minnick - Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1207 D Street, N. E., Washington, D. C. 20002

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rock Creek Cemetery

Date

6/27/97

20c. Location - City or Town, State

Washington, D. C.

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

STEWART FUNERAL HOME, Inc.

4001 Benning Road, N.E., Washington, D. C.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Arteriosclerotic Cardiovascular Disease years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebral infarction

Carcinoma Larynx

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

N/A

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John T. Stewart III

29c. License number

D01852

29d. Date signed (Month, Day, Year)

JUNE 24 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

PAUL A. DeVORE, MD 4203 QUEENSBURY Rd Hyattsville MD 2078

31. Date filed (Month, Day, Year)

JUN 21 1997

32. Registrar's Signature

John T. Stewart III

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed within 24 hours after death. To the Hospital or Attending Physician: After this certificate has been signed by the attending physician and to the Funeral Director: After this certificate has been signed by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Lucy Minnick - Mother

x

Rock Creek Cemetery 6/27/97 Washington, D. C.

STEWART FUNERAL HOME, Inc.
4001 Benning Road, N.E., Washington, D. C.

1207 D Street, N. E., Washington, D. C. 20002

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21079

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Cora Virginia Mayberry				2. Date of Death Month Day Year June 18, 1997				3. Time of Death 2:00 am													
	4a. Facility Name (If not institution, give street and number) 14510 Homecrest Road #1016				4b. City, Town, or Location of Death Silver Spring				4c. County of Death Montgomery													
Funeral Director	5. Social Security Number 577-20-0111		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) April 21, 1921		9. Birthplace (State or Foreign Country) Washington, D.C.													
	Usual Residence of Decedent																					
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
10e. Street and Number 14510 Homecrest Road #1016				10f. Zip Code 20906		10g. Citizen of What Country? U.S.A.																
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White														
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Food Server			16b. Kind of Business/Industry Cafeteria															
17. Father's Name (First, Middle, Last) George Blake					18. Mother's Name (First, Middle, Maiden Surname) Esther Gill																	
19a. Informant's Name/Relationship (Type, Print) William Mayberry - Husband					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5999 Emerson Street, Bladensburg, Maryland 20710																	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		Date 6/21/97		20c. Location - City or Town, State Brentwood, Maryland															
21. Signature of Funeral Service Licensee Nancy J. Thompson					22. Name and Address of Facility Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781																	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																						
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Chronic Obstructive Pulmonary Disease</td> <td rowspan="4"> Approximate Interval Between Onset and Death Years </td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td colspan="2">d.</td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Chronic Obstructive Pulmonary Disease	Approximate Interval Between Onset and Death Years	Due to (or as a consequence of):		b.	Due to (or as a consequence of):	c.	Due to (or as a consequence of):	d.		
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Chronic Obstructive Pulmonary Disease	Approximate Interval Between Onset and Death Years																			
	Due to (or as a consequence of):																					
	b.	Due to (or as a consequence of):																				
	c.	Due to (or as a consequence of):																				
d.																						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension							23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown															
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred													
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)															
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																						
29b. Signature and title of certifier [Signature] MD			29c. License number D 3516 Z		29d. Date signed (Month, Day, Year) June 19, 1997																	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Michael S. Schindler, M.D. 10801 Lockwood Drive #200, Silver Spring, MD 20901																						
31. Date filed (Month, Day, Year) JUN 23 1997			32. Registrar's Signature [Signature]																			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

1997 12 11

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21080

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Paul Marionni

2. Date of Death

Month Day Year
JUNE 19, 1997

3. Time of Death

20:52 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

University of Maryland Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

5. Social Security Number

173-38-1216

6. Sex

15 M 2 F

7. Age (In yrs. last birthday)

49 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 27, 1947

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Greenbelt

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

4-G Ridge Road

10f. Zip Code

20770

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Astrophysicist

16b. Kind of Business/Industry

NASA

17. Father's Name (First, Middle, Last)

Samuel Salvatore Marionni

18. Mother's Name (First, Middle, Maiden Surname)

Claire M. Cocchini

19a. Informant's Name/Relationship (Type, Print)

Joan T. Marionni - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4-G Ridge Road, Greenbelt, Maryland 20770

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metropolitan Crematory

Date

06/22/97

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Claudette L. Saack

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.

4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)e. Sepsis
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

one week

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy
performed?

1 Yes 2 No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1 Yes 2 No

25. Was case referred to medical
examiner?

1 Yes 2 No

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending
2 Accident investigation
3 Suicide 6 Could not be
4 Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

J. Kuruppu

29c. License number

P10209

29d. Date signed (Month, Day, Year)

JUNE 19, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JANAKI KURUPPU, 22 S. GREENE ST, BALTIMORE

31. Date filed (Month, Day, Year)

JUN 23 1997

32. Registrar's Signature

John Anderson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21081

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WILL FORD MATTHEWS

2. Date of Death

Month Day Year
June 20 1997

3. Time of Death

06.20 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital

4b. City, Town, or Location of Death

Chercheny

4c. County of Death

Prince George's

5. Social Security Number

241 607338

6. Sex

1X M 2 F

7. Age (In yrs. last birthday)

60 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
Nov 18, 1936

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State 10b. County 10c. City, Town or Location
MD Prince George's Seat Pleasant

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

6815 HASTING DRIVE

10f. Zip Code

20743

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Truck DRIVER

16b. Kind of Business/Industry

Self-Employed

17. Father's Name (First, Middle, Last)

Mossett L. Matthews

18. Mother's Name (First, Middle, Maiden Surname)

Allie Frances Boykin

19a. Informant's Name/Relationship (Type, Print)

Milford D. Matthews

Butler

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

156 Hobson St, Newark, NJ 07112

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hillcrest Mem Park

Date

3/4/97

20c. Location - City or Town, State

Clinton, NC

21. Signature of Funeral Service Licensee

Nelson E. Greenup

22. Name and Address of Facility

GREENE FUNERAL HOME
814 Franklin Street
Alexandria, VA 22314

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Respiratory failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Sudden

b. Hypotension

Due to (or as a consequence of):

Sudden

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Dehydration

Due to (or as a consequence of):

Days

d. Metastatic Carcinoma

Months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Gastric Carcinoma
Hepatic Metastases

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending investigation
2 Accident 6 Could not be determined
3 Suicide 4 Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Nelson E. Greenup MD

29c. License number

D-32332

29d. Date signed (Month, Day, Year)

06/24/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SK Gupta MD 9801 Georgia Ave # 220

SILVER SPRING MD 20902

31. Date filed (Month, Day, Year)

JUN 24 1997

32. Registrar's Signature

John D. Anderson

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended # 8. & 9. P.G.C. 6-25-97 cr

Certificate of Death

Reg. No.

97 21082

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GROVER MILLER SR.

2. Date of Death

Month Day Year
JUNE 17, 1997

3. Time of Death

10:28 PM

4a. Facility Name (If not institution, give street and number)

PRINCE GEORGES HOSPITAL CENTER

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

577-24-2559

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Raleigh, NC
June 6, 1922

9. Birthplace (State or Foreign Country)

Raleigh
6/6/22 North Carolina

Usual Residence of Decedent

10a. State

MD

10b. County

PG

10c. City, Town or Location

BLADENSBURG

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

5802 ANNAPOLIS ROAD

10f. Zip Code

20710

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No
If Yes, Give Year Dates
6/15/43-1/20/46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 YEARS

College (1-4 or 5+)

NONE

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

FED GOVT (SEC)

16b. Kind of Business/Industry

FEDERAL GOVERNMENT

17. Father's Name (First, Middle, Last)

ROSCOE C. MILLER

18. Mother's Name (First, Middle, Maiden Surname)

MARGARET POWELL

19e. Informant's Name/Relationship (Type, Print)

GROVER C. MILLER, JR. (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

729 FAIRMONT ST NW, DC 20010

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

LINCOLN MEMORIAL CEMETERY

Date

6/23/97

20c. Location - City or Town, State

SUITLAND MD.

21. Signature of Funeral Service Licensee

Juan Smith

22. Name and Address of Facility

JOHN T. RHINES CO., INC.
3030 12TH ST NE, DC 20017

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

e. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Immediate Cause (Final disease or condition resulting in death)

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

{

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☒ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury et Work?

☐ Yes ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MARIO F. GOLVER JR MD

29c. License number

DEPUTY MEDICAL EXAMINER
D 33954

29d. Date signed (Month, Day, Year)

JUNE 19, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARIO F. GOLVER JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

31. Date filed (Month, Day, Year)

JUN 25 1997

32. Registrar's Signature

J. Anderson

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21083

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Louis Martino				2. Date of Death Month Day Year June 24, 1997		3. Time of Death 9:55 p.m.			
	4a. Facility Name (If not institution, give street and number) 5522 Hill Way				4b. City, Town, or Location of Death Camp Springs		4c. County of Death Prince George's			
Funeral Director	5. Social Security Number 577-62-5069		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 50 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 8, 1946	9. Birthplace (State or Foreign Country) Washington, D.C.		
	Usual Residence of Decedent									
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Camp Springs			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 5522 Hill Way				10f. Zip Code 20746		10g. Citizen of What Country? U.S.A.				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1965-68		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sr. Computer Engineer		16b. Kind of Business/Industry ECI System & Engineering				
17. Father's Name (First, Middle, Last) Joseph Francis Martino				18. Mother's Name (First, Middle, Maiden Surname) Constance Cannata						
19a. Informant's Name/Relationship (Type, Print) Mary Ann Martino/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5522 Hill Way, Camp Springs, Md. 20746						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cem. 6/27/97		Date 6/27/97		20c. Location - City or Town, State Arlington, Virginia				
21. Signature of Funeral Service Licensee <i>Robert P. Kalas</i>				22. Name and Address of Facility George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Maryland						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <u>METASTATIC LUNG CANCER</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death 4 YRS	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Steph Stahl MD</i>		29c. License number D18912		29d. Date signed (Month, Day, Year) 6/25/97				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) STEPHEN STAHL 8300 CORPORATE DR LANDOVER MD 20785										
31. Date filed (Month, Day, Year) JUN 26 1997		32. Registrar's Signature <i>John Anderson Randall</i>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

97 21084

7-7-97 ITEMS # 28a.thru 28f. Per M.E.O. P.G.C. cr Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) VICTOR MELLEN			2. Date of Death Month JUNE Day 15 Year 1997		3. Time of Death 12:45 AM		
4a. Facility Name (If not institution, give street and number) HEARTLAND OF HYATTSVILLE			4b. City, Town, or Location of Death HYATTSVILLE		4c. County of Death PRINCE GEORGES		
5. Social Security Number 579-84-8296		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 40 Yrs.		8. Date of Birth (Month, Day, Year) NOV. 10, 1956	
9. Birthplace (State or Foreign Country) WASH, DC		10a. State MD		10b. County PRINCE GEORGE'S		10c. City, Town or Location FORESTVILLE	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 3305 PINEVALE AVE.		10f. Zip Code 20747		10g. Citizen of What Country? USA	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CONSTRUCTION		16b. Kind of Business/Industry PVT.			
17. Father's Name (First, Middle, Last) EDWIN MELLEN			18. Mother's Name (First, Middle, Maiden Surname) THURIDOR UNKNOWN				
19a. Informant's Name/Relationship (Type, Print) THURIDOR MELLEN/ MOTHER			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3305 PINEVALE AVE. FORESTVILLE, MD 20747				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) METROPOLITAN CREMATORY		20c. Location - City or Town, State 6-19-97 ALEXANDRIA, VA			
21. Signature of Funeral Service Licensee Shawara L. Braxton			22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD 4308 SUITLAND RD. SUITLAND, MD 20746				

Baltimore, Maryland 21215-0020
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CARDIO RESPIRATORY FAILURE Due to (or as a consequence of): SIP MVA & CLOSED HEAD INJURY Due to (or as a consequence of): SEIZURE DISORDER 2° INJURY Due to (or as a consequence of): AIDS		Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day, Year) March 12, 97		28b. Time of Injury 06:50p M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred. N/A Traveling in wheel-chair and struck by auto	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) N/A Street		28f. Location (Street and Number or Rural Route Number, City or Town, State) N/A Forestville, Maryland and Marib. Pike & Pumphrey Dr.	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. Signature and title of certifier Imran Chowdhury, M.D.		29c. License number D 42019	
29d. Date signed (Month, Day, Year) June 19, 1997		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Imran Chowdhury, M. D. 7350 Van-Dusen Road, Laurel, MD 20707	
31. Date filed (Month, Day, Year) JUN 20 1997		32. Registrar's Signature Jodi Anderson-Rodell	

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 21085**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SUSIE CATHERINE MYERS

2. Date of Death

Month
JuneDay
23Year
1997

3. Time of Death

9:45 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Doctors Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince Georges

5. Social Security Number

219-56-1060

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
APR. 26, 1918

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

PRINCE GEORGES

10c. City, Town or Location

GREENBELT

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

44R RIDGE ROAD

10f. Zip Code

20770

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

OWNED HOME

17. Father's Name (First, Middle, Last)

THOMAS HILLARY SMITH

18. Mother's Name (First, Middle, Maiden Surname)

MINNIE VIOLA HATFIELD

19a. Informant's Name/Relationship (Type, Print)

ALICE L. HALEY, DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10808 HOLLAWAY DR., UPPER MARLBORO, MD 20770

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

FORT LINCOLN CEMETERY

Date

6/27/97

20c. Location - City or Town, State

BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

FORT LINCOLN FUNERAL HOME

3401 BLADENSBURG RD., BRENTWOOD, MD

20722

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

e.

Septic Shock

Due to (or as a consequence of):

b.

Ischemic a gangrene bowel

Due to (or as a consequence of):

c.

Bowel obstruction

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

5 HRS

24 hrs

3 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Resp failure

Congestive heart failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

1

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D206 33

29d. Date signed (Month, Day, Year)

6/24/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILHELMINA M. CRUZ, M.D., 7700 OLD BRANCH AVENUE, #D205, CLINTON, MD 20735

31. Date filed (Month, Day, Year)

JUN 26 1997

32. Registrar's Signature

John Andrew Carroll

State
RegistrarSUSIE CATHERINE MYERS
Baltimore, Maryland 21215-0020

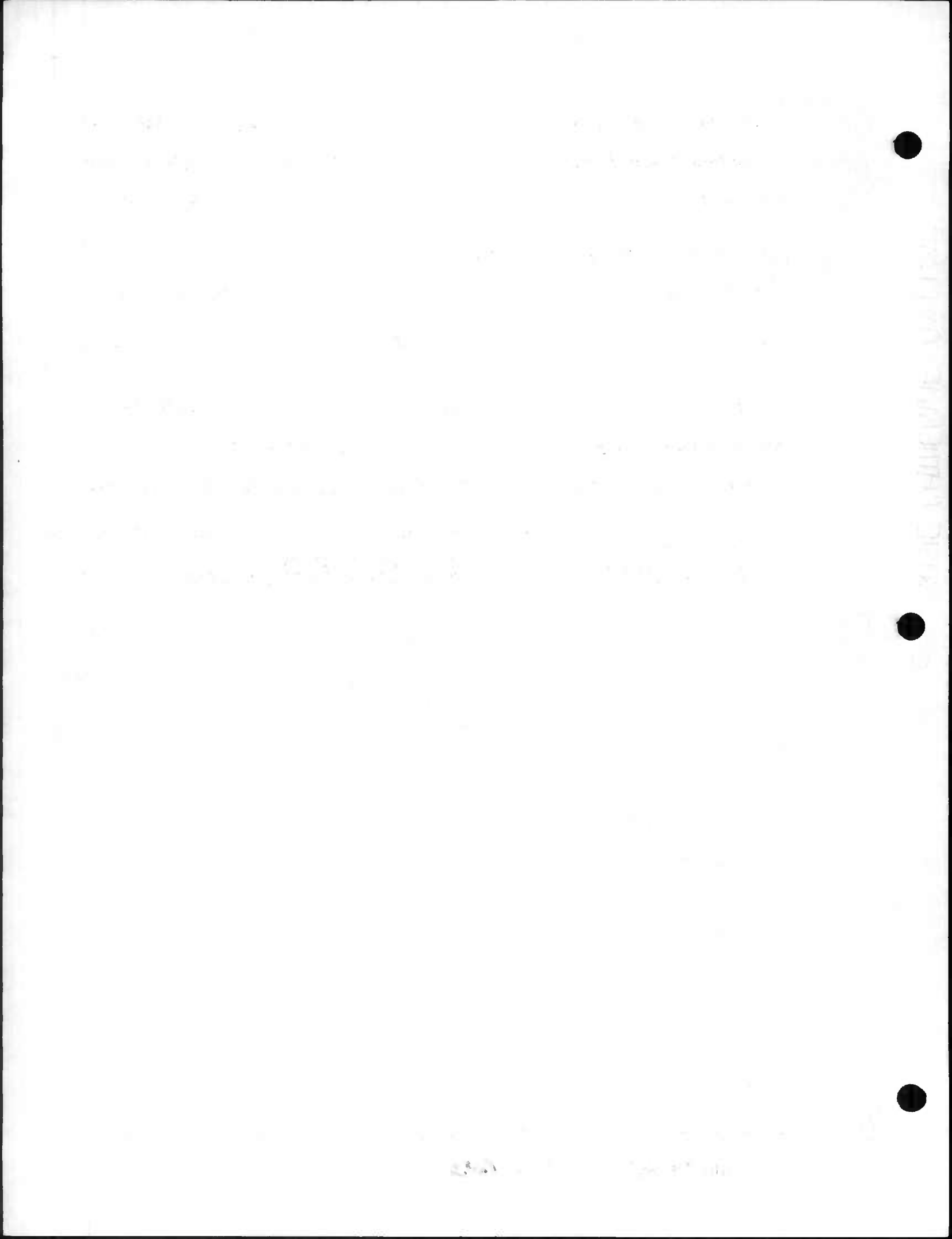
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97 21086

Reg. No.

**Physician
/Medical
Examiner**

1. Decedent's Name (First, Middle, Last) Preshasa Ortiz				2. Date of Death Month Day Year May 29 1997		3. Time of Death 2:25 P.M.	
4a. Facility Name (If not institution, give street and number) St. Mary's Hospital				4b. City, Town, or Location of Death Leonardtown		4c. County of Death St. Mary's	
5. Social Security Number n/a	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 29, 1997	9. Birthplace (State or Foreign Country) Maryland	

**Funeral
Director**

To Be Completed by Funeral Director

Usual Residence of Decedent		10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Lexington Park		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 45999 Great Mills Court				10f. Zip Code 20653		10g. Citizen of What Country? United States			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify Puerto Rican			14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) n/a College (1-4or 5+) n/a			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) n/a			16b. Kind of Business/Industry n/a			
17. Father's Name (First, Middle, Last) Lamont Ortiz					18. Mother's Name (First, Middle, Maiden Surname) Leslie Maria Carter				
19a. Informant's Name/Relationship (Type, Print) Leslie Maria Carter, Mother					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45999 Great Mills Court, Lexington Park, Maryland 20653				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Charles Memorial Gardens		Date 6-2-1997		20c. Location - City or Town, State Leonardtown, Maryland		
21. Signature of Funeral Service Licensee Edward N. Brinsfield, Jr., MD0052					22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, Maryland 20650-0279				

**Physician
/Medical
Examiner**

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Premature Delivery Due to (or as a consequence of): b. Chorioamnionitis Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ { Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 2 hours 48 hours	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier MD			29c. License number D 50618		29d. Date signed (Month, Day, Year) 5/29/97
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOYCE NEAL M.D. LEONARDTOWN, MD. 20650					
31. Date filed (Month, Day, Year) JUN 04 1997		32. Registrar's Signature 			

**State
Registrar**

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

NAME: Preshasa Ortiz
 Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

THE
OFFICE OF THE
ATTORNEY GENERAL
STATE OF NEW YORK

IN SENATE
JANUARY 21, 1964

REPORT
OF THE
COMMISSIONER OF THE
DEPARTMENT OF SOCIAL SERVICES

IN RESPONSE TO
RESOLUTION NO. 100
PASSED BY THE SENATE
ON JANUARY 14, 1964

ALBANY, NEW YORK
JANUARY 21, 1964

TO THE SENATE
FROM THE COMMISSIONER OF THE
DEPARTMENT OF SOCIAL SERVICES

RE: THE DEPARTMENT OF SOCIAL SERVICES
AND THE DEPARTMENT OF CORRECTIONS
AND JAIL

1. The Department of Social Services has the honor to acknowledge the receipt of your letter of January 14, 1964, regarding the report of the Department of Social Services on the subject of the Department of Corrections and Jail.

2. The Department of Social Services has the honor to acknowledge the receipt of your letter of January 14, 1964, regarding the report of the Department of Social Services on the subject of the Department of Corrections and Jail.

3. The Department of Social Services has the honor to acknowledge the receipt of your letter of January 14, 1964, regarding the report of the Department of Social Services on the subject of the Department of Corrections and Jail.

4. The Department of Social Services has the honor to acknowledge the receipt of your letter of January 14, 1964, regarding the report of the Department of Social Services on the subject of the Department of Corrections and Jail.

5. The Department of Social Services has the honor to acknowledge the receipt of your letter of January 14, 1964, regarding the report of the Department of Social Services on the subject of the Department of Corrections and Jail.

6. The Department of Social Services has the honor to acknowledge the receipt of your letter of January 14, 1964, regarding the report of the Department of Social Services on the subject of the Department of Corrections and Jail.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21087

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James Lester Pugh

2. Date of Death

Month Day Year
June 28 1997

3. Time of Death

1402

4a. Facility Name (If not institution, give street and number)

Harford Memorial Hospital

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

5. Social Security Number

217-18-1823

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

91

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 24 1906

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

MD

10b. County

Cecil

10c. City, Town or Location

Conowingo

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1083 Rock Springs Rd

10f. Zip Code

21918

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Signalman

16b. Kind of Business/Industry

Railroad

17. Father's Name (First, Middle, Last)

Ambrose Pugh

18. Mother's Name (First, Middle, Maiden Surname)

Dehli Roup

19a. Informant's Name/Relationship (Type, Print)

Shirley A. Horton, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1082 Rock Springs Rd. Conowingo MD 21918

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

BelAir Memorial Gardens 7-1-1997

Date

20c. Location - City or Town, State

BelAir MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

R. T. Foard Funeral Home, P.A.

111 S. Queen St. Rising Sun MD 21911

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. Coronary Artery Disease
Due to (or as a consequence of):b. Aortic Aneurysm
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Lastc. _____
Due to (or as a consequence of):d. _____
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

04/06/1997

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending
investigation6 ☐ Could not be
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury28c. Injury et
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

H. Sup Sim MD

29c. License number

D46412

29d. Date signed (Month, Day, Year)

6/29/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

319 S. Union Ave Havre de Grace MD 21078

Hi Sup Sim

31. Date filed (Month, Day, Year)

JUL 01 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
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/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

97 21088

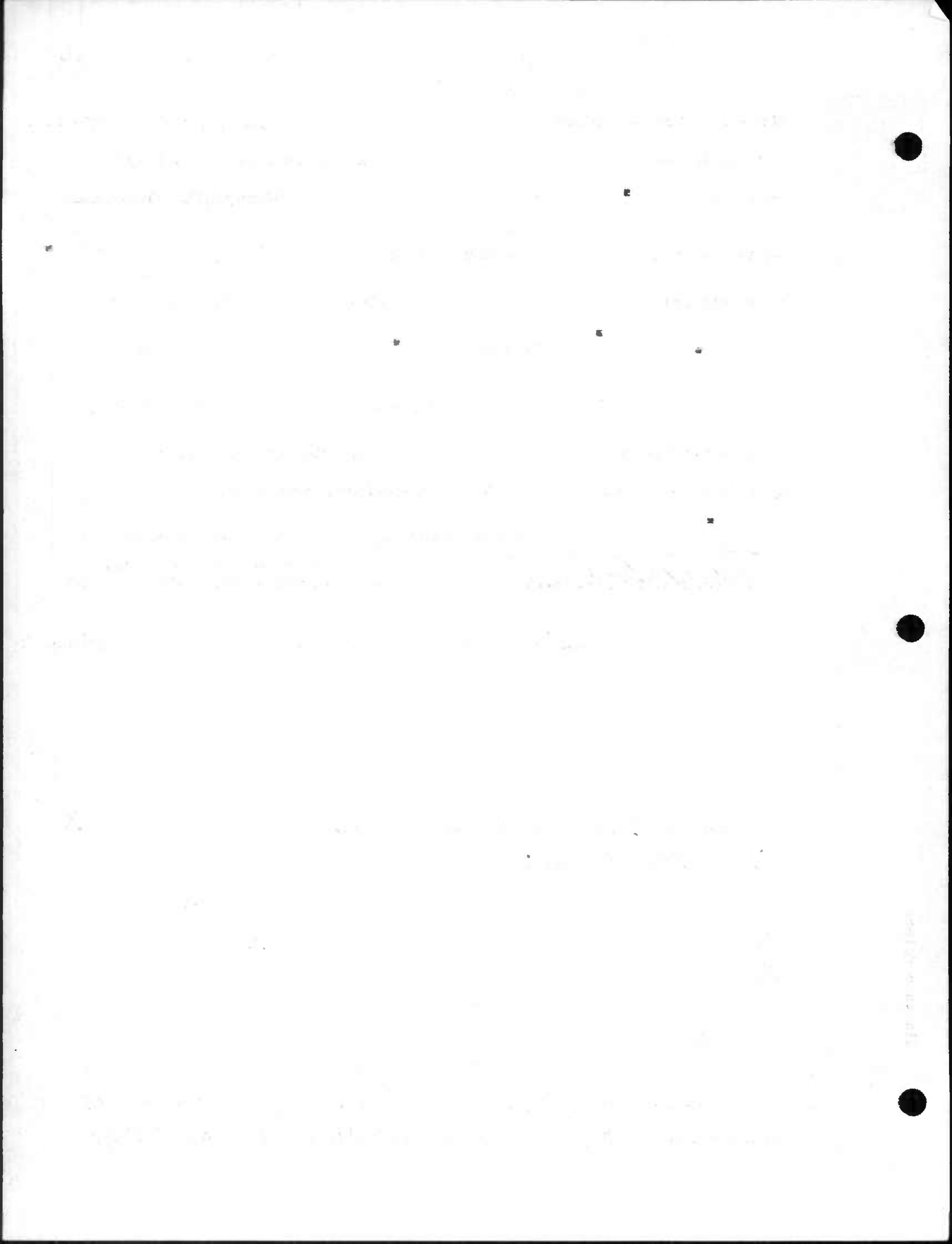
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Clarence Merton Palmer					2. Date of Death Month Day Year June 16, 1997			3. Time of Death 6:56 p.m.	
	4e. Facility Name (If not institution, give street and number) 512 Towely Court					4b. City, Town, or Location of Death Lexington Park			4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 004-22-1288		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) February 8, 1928		9. Birthplace (State or Foreign Country) New Hampshire	
	Usual Residence of Decedent									
10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Lexington Park				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 512 Towely Court					10f. Zip Code 20653			10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1946-1949		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Field Engineer			16b. Kind of Business/Industry Defense Contracting			
17. Father's Name (First, Middle, Last) John Davis Palmer					18. Mother's Name (First, Middle, Maiden Surname) Blanche Gertrude Rogers					
19a. Informant's Name/Relationship (Type, Print) Phyllis M. Charles, Sister					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 5, Brownfield, Maine 04010					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory			20c. Location - City or Town, State 6-18-97 Alexandria, Virginia				
21. Signature of Funeral Service Licensee <i>Edward N. Brinsfield, Jr.</i> Edward N. Brinsfield, Jr.					22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, Maryland 20650-0279					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>e. End Stage Emphysema Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p>15 yrs</p> </div> </div> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Insulin Dependent Diabetes Mellitus Obesity Morbid										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>Gayle Jones, M.D.</i>					29c. License number D30111		29d. Date signed (Month, Day, Year) June 16, 1997			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gary W. Jones MD 11305 Pitsea Dr. Beltsville Md 20705-1757										
31. Date filed (Month, Day, Year) JUN 18 1997					32. Registrar's Signature <i>John Davidson Randall</i>					

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

641



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21089

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Francis Bryan Potter				2. Date of Death Month Day Year June 10, 1997		3. Time of Death 5:47 AM	
	4e. Facility Name (If not institution, give street and number) 22680 Cedar Lane Court, #1214				4b. City, Town, or Location of Death Leonardtown		4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 579-16-8974		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) Apr 14, 1909	
	9. Birthplace (State or Foreign Country) Maryland		10. Usual Residence of Decedent 10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Leonardtown	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 22680 Cedar Lane Court #1214		10f. Zip Code 20650		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th Grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HVAC Engineer		16b. Kind of Business/Industry U.S. Government				
17. Father's Name (First, Middle, Last) Edward Rich Potter		18. Mother's Name (First, Middle, Maiden Surname) Clara Mae Twilley		19a. Informant's Name/Relationship (Type, Print) Alice D. Lavender/Niece		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22030 Society Hill Road, Leonardtown, MD 20650		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. George Isl. Un Meth. Cem		20c. Location - City or Town, State Piney Point, MD		20d. Date 6/13/97		
21. Signature of Funeral Service Licensee <i>Michael K. Gardiner</i>		22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>Acute Cerebrovascular Accident</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death <i>minutes</i>		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>[Signature]</i>		29c. License number D19917		29d. Date signed (Month, Day, Year) 6/10/97				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James C. Boyd, M.D. California, MD 20619								
31. Date filed (Month, Day, Year) JUN 12 1997		32. Registrar's Signature <i>John Davidson-Randall</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

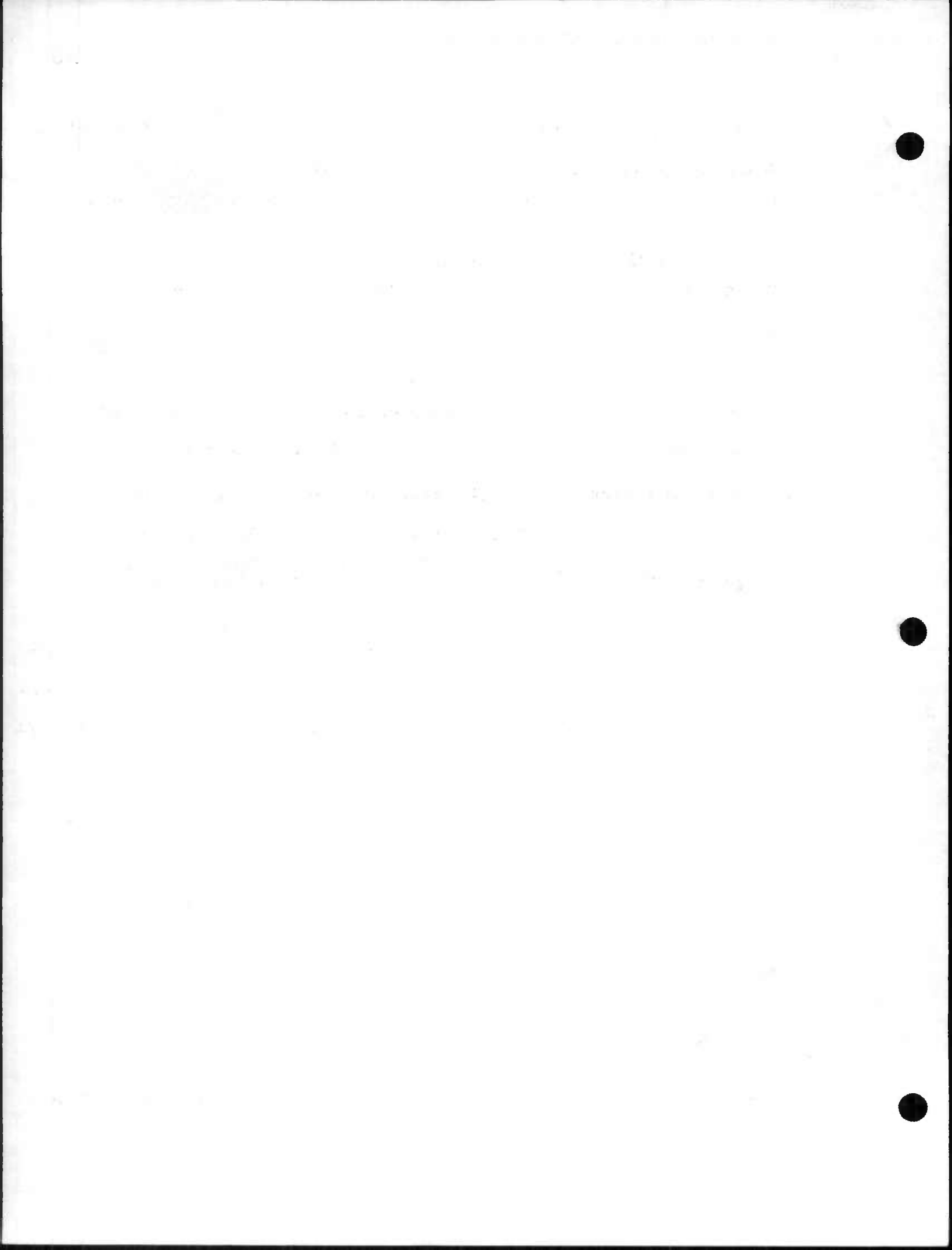
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21090

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EVELYN F. PUGH				2. Date of Death Month Day Year JUNE 21 1997		3. Time of Death 16:45	
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore City	
Funeral Director	5. Social Security Number 217-20-5254		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 1, 1928	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Carroll		10c. City, Town or Location Sykesville	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 1780 Pine Knob Road		10f. Zip Code 21784		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Photographer		16b. Kind of Business/Industry Photography			
	17. Father's Name (First, Middle, Last) Frank Pugh		18. Mother's Name (First, Middle, Maiden Surname) Lillian Cullison					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mrs. Edna Cook (Sister)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 311 Grand Avenue Front Royal, VA 22630					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremation Serv.		Date 6/23/97		20c. Location - City or Town, State Hampstead, MD	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Brian R. Haight		22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL (Box 195) Sykesville, MD 21784 (410)-795-1400					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MYOCARDIAL INFARCTION Due to (or as a consequence of): b. RENAL FAILURE Due to (or as a consequence of): c. ISCHEMIC LEFT LOWER EXTREMITY Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death TEN DAYS NINE DAYS FOUR DAYS					
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Krystn R. Wagner, MD		29c. License number RES-000		29d. Date signed (Month, Day, Year) JUNE 21, 1997	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Hopkins Hospital, Baltimore, Maryland 21205				M.D. Krystn R. Wagner,			
	31. Date filed (Month, Day, Year) JUN 25 1997		32. Registrar's Signature Julia Anderson-Randall					


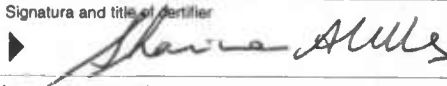



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21091

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Doris Marie Proctor				2. Date of Death Month July , Day 1 , Year 1997				3. Time of Death 9:11 A	
	4a. Facility Name (If not institution, give street and number) 15300 Brandywine Road				4b. City, Town, or Location of Death Brandywine				4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 219-58-8303		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 45 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 23, 1951		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Brandywine				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 15300 Brandywine Road				10f. Zip Code 20613		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. American Indian Specify:		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) N/A				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bus Driver			16b. Kind of Business/Industry Prince George's Co. Schools		
	17. Father's Name (First, Middle, Last) Thomas Ruben Swann				18. Mother's Name (First, Middle, Maiden Surname) Mary Grace Thompson					
	19a. Informant's Name/Relationship (Type, Print) James Francis Proctor (Husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15300 Brandywine Rd. Brandywine, Maryland 20613					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery		20c. Location - City or Town, State Clinton, Maryland		20d. Date July 7, 1997			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, MD 20735					
	23a. Part I. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Immediata Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Cardio-Respiratory Arrest Due to (or as a consequence of): b. Lung Cancer Due to (or as a consequence of): c. Metastasis to Brain, Pancreas Due to (or as a consequence of): d. Anemia									
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
State Registrar	29b. Signature and title of certifier 				29c. License number DE 45296		29d. Date signed (Month, Day, Year) 7-1-97			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shamima Abbas, MD 5100 Auth Way, Camp Springs, Md 20746									
31. Date filed (Month, Day, Year) JUL 02 1997				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21092

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RUTH MILDRED PERKINS

2. Date of Death

JUNE 16 1997

3. Time of Death

03:15 PM
FOUND

4a. Facility Name (If not institution, give street and number)

4011 23RD PARKWAY #31

4b. City, Town, or Location of Death

TEMPLE HILLS

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

578 44 6044

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

DEC 23, 1925

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGES

10c. City, Town or Location

TEMPLE HILL

10d. Inside City Limits

X ☒ Yes 2 ☐ No

10e. Street and Number

4011 23rd PARKWAY

10f. Zip Code

20748

10g. Citizen of What Country?

usa

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CLERK

16b. Kind of Business/Industry

POST OFFICE

17. Father's Name (First, Middle, Last)

LLOYD WALLER

18. Mother's Name (First, Middle, Maiden Surname)

WILLIE DREW MOORE

19a. Informant's Name/Relationship (Type, Print)

SANDRA GREEN (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2005 CHADWICK TERR OXON HILL, MD

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MARYLAND NATIONAL

Data

JUN 21, 1997 LAUREL MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

RALPH WILLIAMS FUNERAL SVC
517 11th STREET S.E.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

DEPUTY MEDICAL EXAMINER
D 33954

29d. Date signed (Month, Day, Year)

JUNE 17, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MARLO F. GOLIE JR MD, 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

31. Date filed (Month, Day, Year)

JUN 27 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

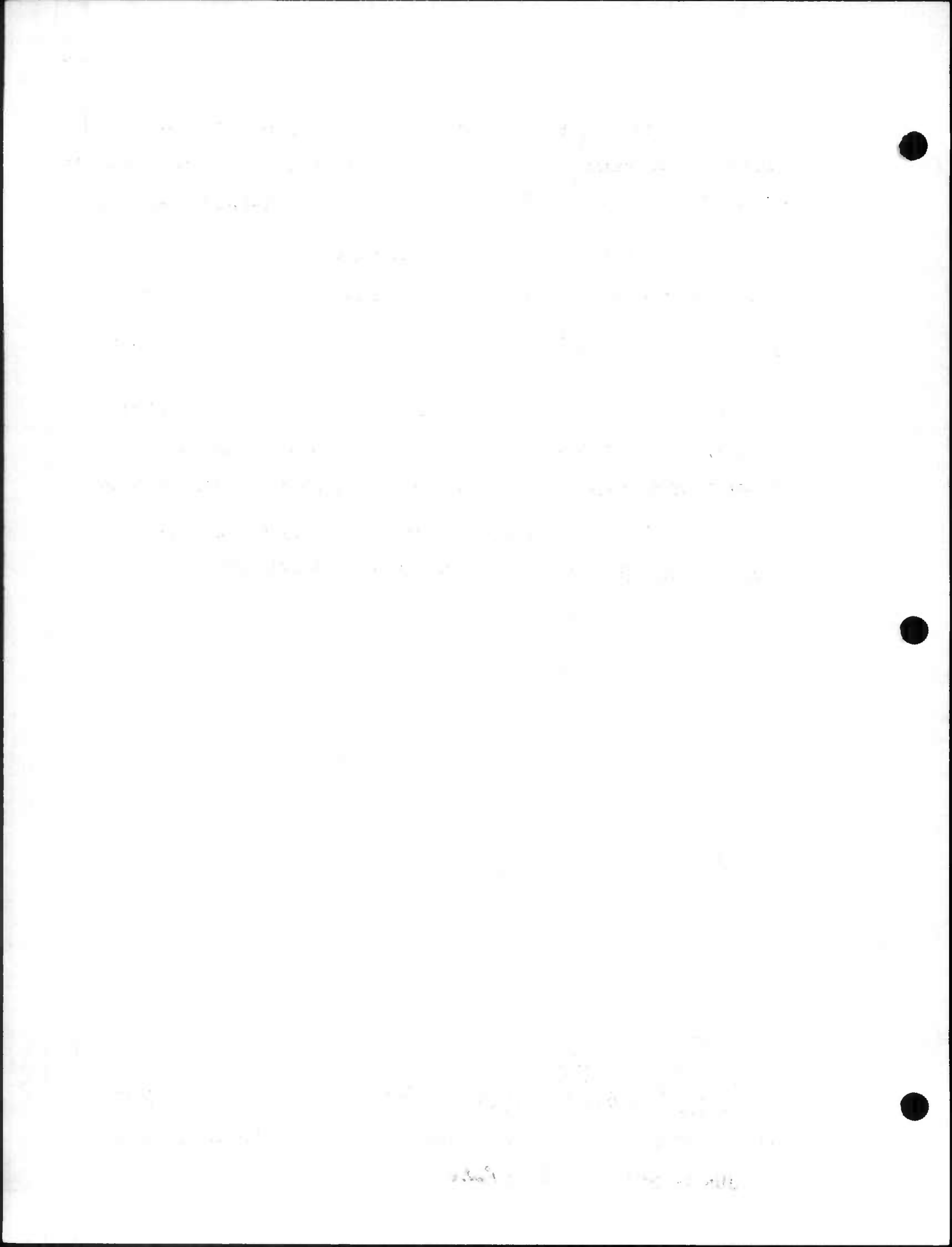
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21093

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Saluda B. Pearson				2. Date of Death Month June Day 21 Year 1997		3. Time of Death 9:23 AM	
	4a. Facility Name (If not institution, give street and number) 9603 Beachwood Avenue				4b. City, Town, or Location of Death Seabrook		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 577-26-9390		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) 02-14-09	
	9. Birthplace (State or Foreign Country) North Carolina		10a. State N/A		10b. County N/A		10c. City, Town or Location Washington DC	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 321 Anacostia Avenue, N.E.		10f. Zip Code 20019	
	10g. Citizen of What Country? USA				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+) Collega	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) File Clerk				16b. Kind of Business/Industry Private			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Benjamin Turner Bryant				18. Mother's Name (First, Middle, Maiden Surname) Christanna Lassiter			
	19a. Informant's Name/Relationship (Type, Print) Garnette Saylor/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7105 97th Avenue, Seabrook, Maryland 20706			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Bryant Cemetery		20c. Location - City or Town, State 6/27/97 Aulander, NC	
	21. Signature of Funeral Service Licenses Nancy A. Perantie				22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Road, Landover, Maryland 20785			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Neoplasm Etiology Unknown Due to (or as a consequence of): b. Large Abdominal Mass Due to (or as a consequence of): c. Anorexia Due to (or as a consequence of): d. Dehydration				Approximate Interval Between Onset and Death			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred			
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Frank B. Doggett, III, M.D.			
To Be Completed by Physician/Medical Examiner	29c. License number DC-11835				29d. Date signed (Month, Day, Year) 6/23/97			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frank B. Doggett, III, M.D. 2815 16th Street, N.E. Washington DC 20018				31. Data filed (Month, Day, Year) JUN 24 1997			
State Registrar	32. Registrar's Signature John Andrew Randall							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21094

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Nancy Elizabeth Painter</i>				2. Date of Death Month <i>June</i> Day <i>21</i> Year <i>1997</i>		3. Time of Death <i>10:00 A.M.</i>	
	4a. Facility Name (If not institution, give street and number) <i>12207 Wynmore Lane</i>				4b. City, Town, or Location of Death <i>Bowie</i>		4c. County of Death <i>Prince George's</i>	
Funeral Director	5. Social Security Number <i>216 38 3296</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>56</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>Sept. 22, 1940</i>	
	9. Birthplace (State or Foreign Country) <i>Maryland</i>		10a. State <i>Maryland</i>		10b. County <i>Prince George's</i>		10c. City, Town or Location <i>Bowie</i>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <i>12207 Wynmore Lane</i>		10f. Zip Code <i>20715</i>		10g. Citizen of What Country? <i>United States</i>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>1</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Administrative Assistant</i>		16b. Kind of Business/Industry <i>Hughes STX Corp.</i>			
	17. Father's Name (First, Middle, Last) <i>William Russell Gray</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Mary Hilda Coster</i>					
	19a. Informant's Name/Relationship (Type, Print) <i>Mary Adams Daughter</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>13003 Viewpoint Lane Bowie Md. 20715</i>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Druid Ridge Cemetery June 25, 1997</i>		20c. Location - City or Town, State <i>Pikesville Md.</i>			
	21. Signature of Funeral Service Licensee <i>Michael DeLeon</i>		22. Name and Address of Facility <i>Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Md. 20715</i>					
	23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): a. <i>metastatic lung cancer</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death <i>2 yrs</i>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <i>M</i>		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>David A. Bortcher, M.D.</i>		29c. License number <i>D16063</i>		29d. Date signed (Month, Day, Year) <i>6-23-97</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>David A. Bortcher, M.D., 14300 Gallant Fox Ln. #118, Bowie, Maryland 20715</i>								
31. Date filed (Month, Day, Year) <i>JUN 24 1997</i>		32. Registrar's Signature <i>John Anderson</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

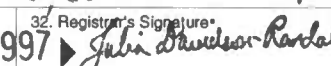
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21095

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANNA M. REID				2. Date of Death Month: 6 Day: 21 Year: 97		3. Time of Death 8:20 A							
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO							
Funeral Director	5. Social Security Number 213-22-6337	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 03/15/1927		9. Birthplace (State or Foreign Country) KENTUCKY						
	Usual Residence of Decedent													
To Be Completed by Funeral Director	10a. State MARYLAND	10b. County SOMERSET	10c. City, Town or Location PRINCESS ANNE			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
	10e. Street and Number 12623 EAST RIDGE ROAD			10f. Zip Code 21853		10g. Citizen of What Country? U.S.								
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE		16b. Kind of Business/Industry OWN HOME									
	17. Father's Name (First, Middle, Last) ELBERT RYLE				18. Mother's Name (First, Middle, Maiden Surname) EFFIE WEBSTER									
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) THEODORE REID/HUSBAND			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12623 EAST RIDGE ROAD, PRINCESS ANNE, MD. 21853										
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BEECHWOOD CEMETERY		Date 6/24/97		20c. Location - City or Town, State PRINCESS ANNE, MD.							
	21. Signature of Funeral Service Licensee  MO0295			22. Name and Address of Facility HINMAN FUNERAL HOME 11673 SOMERSET AVE., PRINCESS ANNE, MD. 21853										
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
	<table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. myocardial infarction</td> <td rowspan="4">Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death 2 weeks</td> </tr> <tr> <td>b. aortic stenosis</td> </tr> <tr> <td>c. coronary artery disease</td> </tr> <tr> <td>d.</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. myocardial infarction	Due to (or as a consequence of):	Approximate Interval Between Onset and Death 2 weeks	b. aortic stenosis	c. coronary artery disease
Immediate Cause (Final disease or condition resulting in death)	a. myocardial infarction	Due to (or as a consequence of):	Approximate Interval Between Onset and Death 2 weeks											
	b. aortic stenosis													
	c. coronary artery disease													
	d.													
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pneumonia, chronic obstructive pulmonary disease						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)												
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  MD		29c. License number D30853		29d. Date signed (Month, Day, Year) 6/21/97								
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Charles B. Silvia, Jr MD PRMC														
31. Date filed (Month, Day, Year) JUN 24 1997		32. Registrar's Signature 												

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

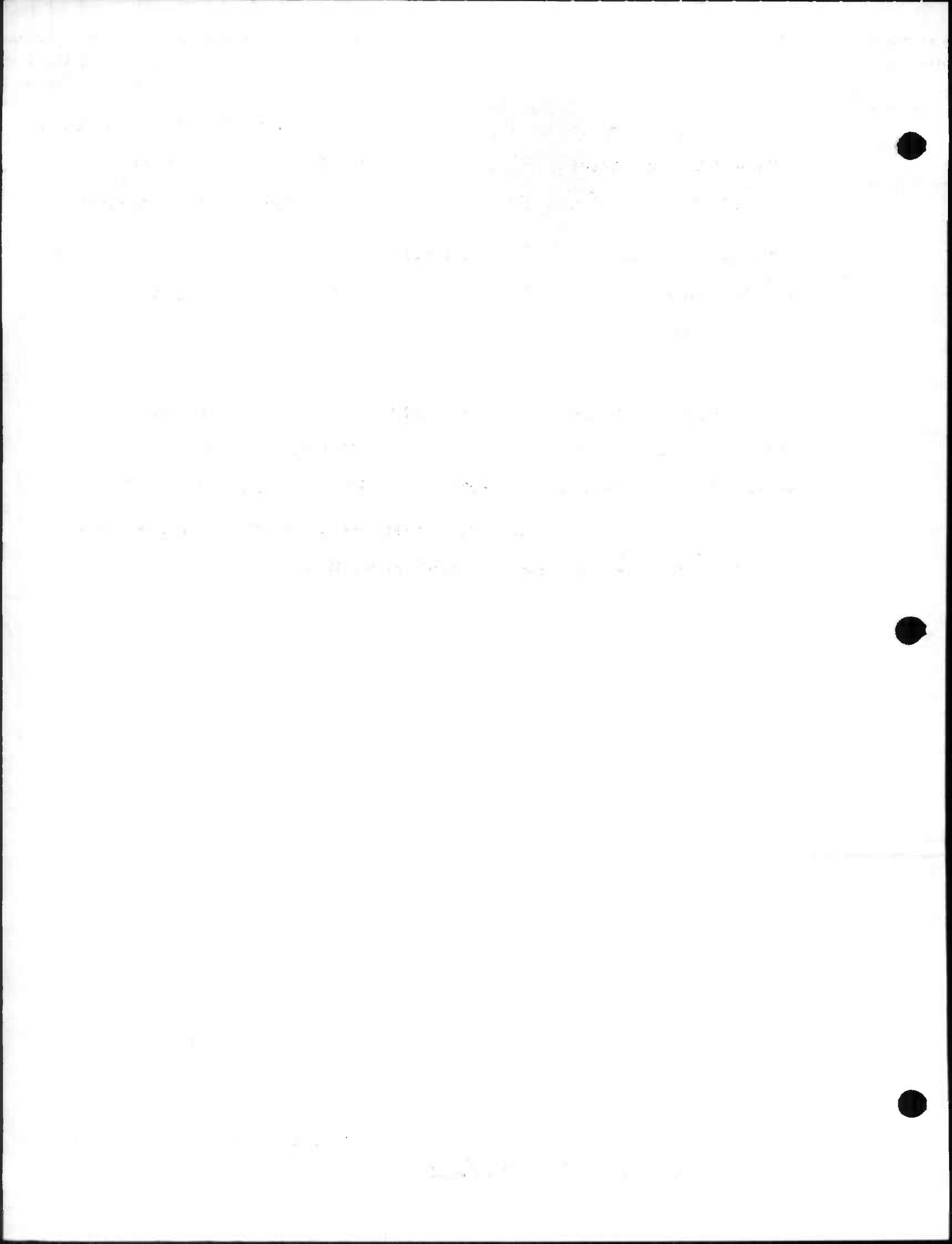
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21096

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ruth T. Reese				2. Date of Death Month Day Year June 19, 1997				3. Time of Death 3:25 A.M.		
	4a. Facility Name (If not institution, give street and number) Home- 4958 Canal Drive				4b. City, Town, or Location of Death Crisfield				4c. County of Death Somerset		
Funeral Director	5. Social Security Number 218-34-9491		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 60 Yrs.		8. Date of Birth (Month, Day, Year) May 2, 1937		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State Maryland		10b. County Somerset		10c. City, Town or Location Crisfield				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 4958 Canal Drive				10f. Zip Code 21817		10g. Citizen of What Country? U.S.A.				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) H. S. Graduate College (1-4 or 5+) 3 Years				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Registered Nurse			16b. Kind of Business/Industry Medical			
	17. Father's Name (First, Middle, Last) Albert D. Tawes				18. Mother's Name (First, Middle, Maiden Surname) Ella Ruth Harris						
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Richard D. Reese (Husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4958 Canal Drive - Crisfield, MD 21817						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Paul's Episcopal Cemetery		Date 6/20/97		20c. Location - City or Town, State Marion Station, MD				
	21. Signature of Funeral Service Licensee Robert H. Bradshaw, Jr.				22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, MD 21817						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC BREAST CANCER Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier DR. VIJAY KARUNBUNATHAN		29c. License number D48098		29d. Date signed (Month, Day, Year) 6-19-97					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. VIJAY KARUNBUNATHAN - 201 Hall Highway - Crisfield, MD 21817											
31. Date filed (Month, Day, Year) JUN 20 1997		32. Registrar's Signature John Davidson Russell									



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21097

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James William Rushing				2. Date of Death Month June Day 25 Year 1997		3. Time of Death 12:53p.m.	
	4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital				4b. City, Town, or Location of Death Prince Frederick		4c. County of Death Calvert	
Funeral Director	5. Social Security Number 578 44 1532		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 62 Yrs.		8. Date of Birth (Month, Day, Year) Apr. 9, 1935	
	9. Birthplace (State or Foreign Country) Wash., DC							
Usual Residence of Decedent								
10a. State MD		10b. County Calvert		10c. City, Town or Location North Beach			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 4000 3rd Street				10f. Zip Code 20714		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Korea		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Foreman			16b. Kind of Business/Industry Printing	
17. Father's Name (First, Middle, Last) Alton Leonard Rushing				18. Mother's Name (First, Middle, Maiden Surname) Catherine Julia Roche				
19a. Informant's Name/Relationship (Type, Print) James V. Rushing/son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as 10 above				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date 6-26-97		20c. Location - City or Town, State Alexandria, VA		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Rausch Funeral Home, Owings, MD 20736				
23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p> </div> <div> <p>a. Respiratory failure Due to (or as a consequence of):</p> <p>b. Obstructive Sleep apnea Due to (or as a consequence of):</p> <p>c. Sweet Peripheral Vasc. Ds. Due to (or as a consequence of):</p> <p>d. Diabetes Mellitus</p> </div> <div> <p>Approximate Interval Between Onset and Death</p> </div> </div>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Morbid obesity						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D37588		29d. Date signed (Month, Day, Year) 6/25/97		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Rafik A. Nasr, M.D., Prince Frederick, MD. 20678								
31. Date filed (Month, Day, Year) JUN 27 1997		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

5 1 VA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21098

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOSEPH

2. Date of Death

Month Day Year
JUNE 26, 1997

3. Time of Death

3:30 AM

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

212-54-5387

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

52

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 9, 1945

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Leonardtwn

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

General Delivery

10f. Zip Code

20650

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
9

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Food Service

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Bernard Woodley Ridgell

18. Mother's Name (First, Middle, Maiden Surname)

Mary Nina Heard

19a. Informant's Name/Relationship (Type, Print)

Joseph E. Ridgell, Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

23980 McIntosh Road, Hollywood, Maryland 20636

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Our Lady's Cemetery

Date

6/30/97

20c. Location - City or Town, State

Leonardtwn, Maryland

21. Signature of Funeral Home Licensee

Edward N. Brinsfield, Jr. M00052

22. Name and Address of Facility

Brinsfield Funeral Home, P.A.
22955 Hollywood Road, Leonardtown, MD 2065023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Acute Gastrointestinal Hemorrhage
Due to (or as a consequence of):

Days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Lastb. Multi-system Organ Failure
Due to (or as a consequence of):

Days

c. Coronary Artery Bypass Surgery
Due to (or as a consequence of):

Weeks

d.

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pseudomembranous enterocolitis

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Norton Elson

29c. License number

D20362

29d. Date signed (Month, Day, Year)

June 27, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Norton Elson MD 6525 Bekrest RD Hyattsville MD 20782

31. Date filed (Month, Day, Year)

JUN 30 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

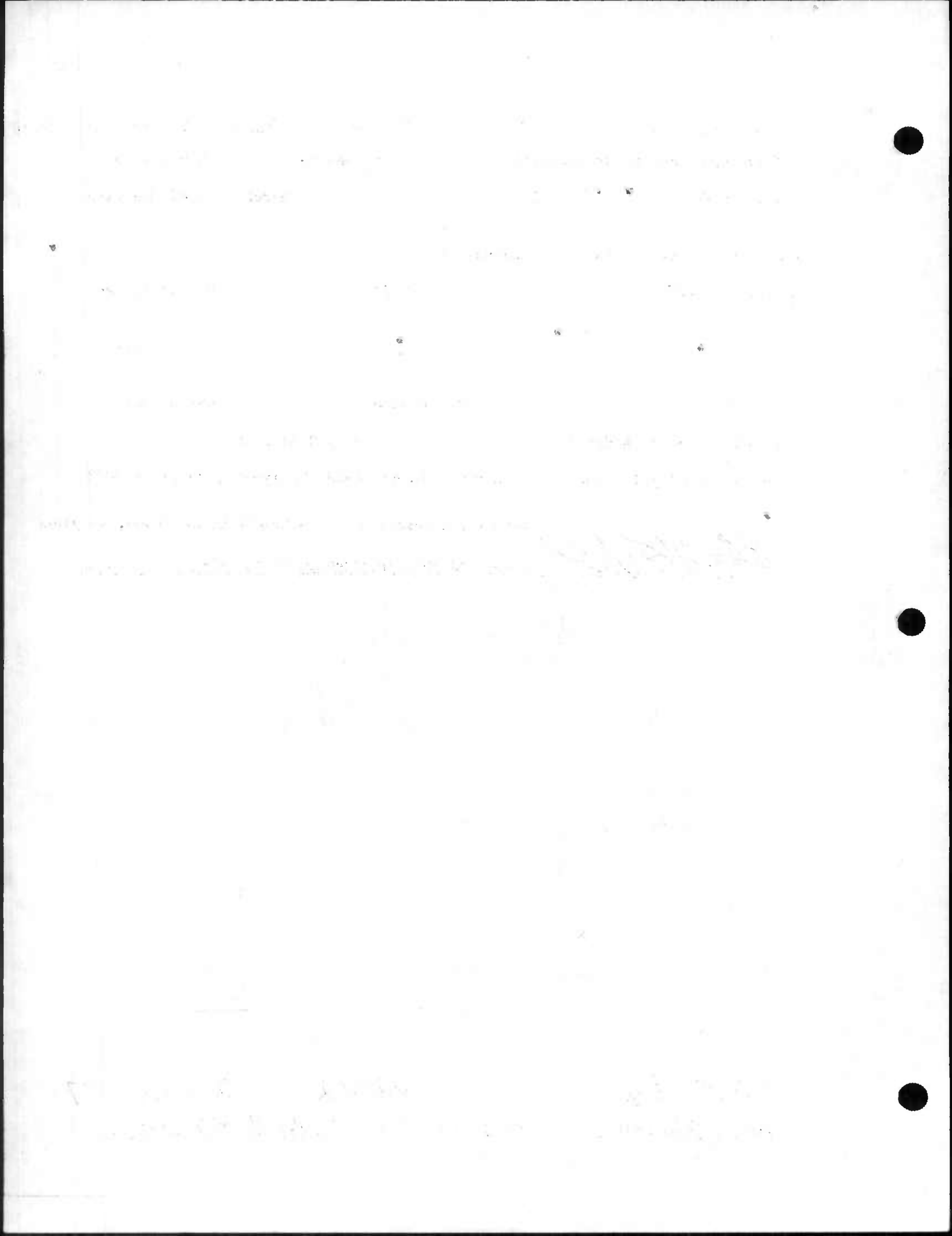
Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21099

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Betty Virgie Russell				2. Date of Death Month May , Day 31 , Year 1997		3. Time of Death 10:00 AM		
	4a. Facility Name (If not institution, give street and number) 21712 Kearsarge Place				4b. City, Town, or Location of Death Lexington Park		4c. County of Death St. Mary's		
Funeral Director	5. Social Security Number 225-24-3482		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) August 9, 1923		
	9. Birthplace (State or Foreign Country) Virginia								
Usual Residence of Decedent									
10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Lexington Park			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 21712 Kearsarge Place				10f. Zip Code 20653		10g. Citizen of What Country? United States			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife			16b. Kind of Business/Industry N/A		
17. Father's Name (First, Middle, Last) Hansford Coffey				18. Mother's Name (First, Middle, Maiden Summa) Sara Eliza Huff					
19a. Informant's Name/Relationship (Type, Print) Martin B. Russell Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 44674 Boxwood Drive, Callaway, Maryland 20620					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Immaculate Heart of Mary		20c. Location - City or Town, State 6/3/97 Lexington Park, MD			
21. Signature of Funeral Service Licensee Edward N. Brinsfield, Jr.				22. Name and Address of Facility Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Probable Myocardial Infarction Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD									
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accidental <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
				28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier William D. Boyd II		29c. License number 014295		29d. Date signed (Month, Day, Year) 6-3-97	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William D. Boyd II, M.D. Leonardtown, Maryland 20650									
31. Date filed (Month, Day, Year) JUN 03 1997				32. Registrar's Signature John Davidson Randall					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21100

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) VERA FRANCES RICHARDSON				2. Date of Death Month Day Year June 10 1997				3. Time of Death 10:15 AM					
	4a. Facility Name (If not institution, give street and number) St. Mary's Nursing Center				4b. City, Town, or Location of Death Leonardtown				4c. County of Death St. Mary's					
Funeral Director	5. Social Security Number 220-32-7034		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 94 Yrs.		8. Date of Birth (Month, Day, Year) August 11, 1902		9. Birthplace (State or Foreign Country) MD					
	Usual Residence of Decedent				10a. State MD		10b. County St. Mary		10c. City, Town or Location Leonardtown		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number 42520 Riverwinds Drive				10f. Zip Code 20650				10g. Citizen of What Country? USA					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner Operator				16b. Kind of Business/Industry Antique Shop					
	17. Father's Name (First, Middle, Last) Samuel Porter Cropper				18. Mother's Name (First, Middle, Maiden Surname) Sarah Martha Gault									
	19a. Informant's Name/Relationship (Type, Print) Leroy Roger Richardson, Jr./Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 42520 Riverwinds Drive, Leonardtown, MD 20650									
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) St. Paul's Methodist Cemetery 6/14/97				20c. Location - City or Town, State Leonardtown, MD					
	21. Signature of Funeral Service Licensee <i>May B. Rizzo</i>				22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650									
	23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one disease on each line. Immediate Cause (Final disease or condition resulting in death) <i>Acute Myocardial Infarction</i>				Due to (or as a consequence of):				Approximate Interval Between Onset and Death <i>Minutes</i>					
	Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>Alzheimer's Disease</i>				Due to (or as a consequence of):									
	Due to (or as a consequence of):													
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Alzheimer's Disease</i>				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) M		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>David C. Allen MD</i>		29c. License number B25230		29d. Date signed (Month, Day, Year) June 11, 1997							
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. David C. Allen 2050 Wildewood Cir, Calif, MD 20619													
	31. Date filed (Month, Day, Year) JUN 16 1997				32. Registrar's Signature <i>John Davidson-Randall</i>									
	State Registrar													

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

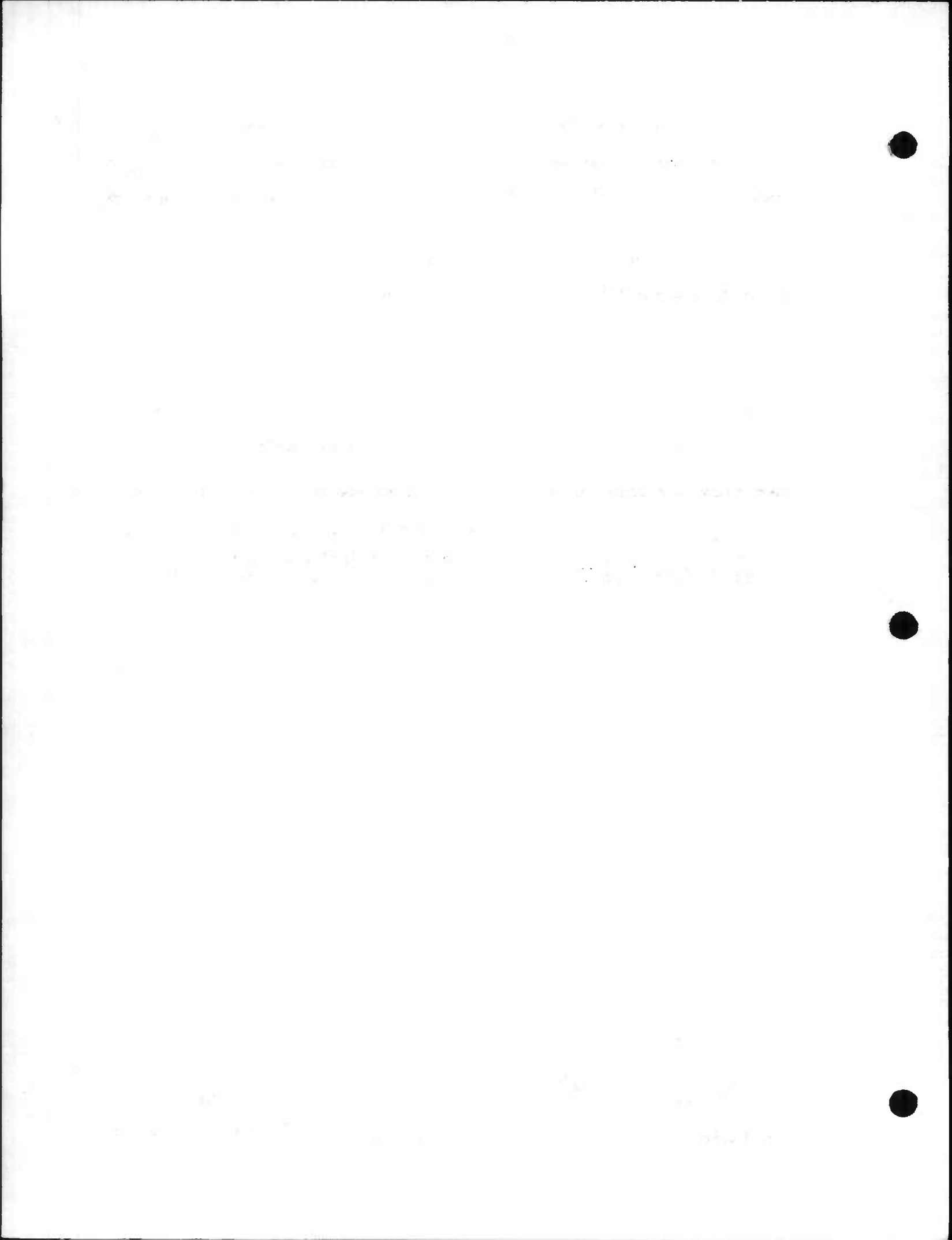
Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

8721101

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RICHARD James

2. Date of Death

Month Day Year
June 12, 1997

3. Time of Death

8:35pm

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Tokoma Park

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

247-14-2662

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 19, 1914

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

District of Columbia

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1616 Marion Street N.W.

10f. Zip Code

20001

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Painter

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

James Robinson

18. Mother's Name (First, Middle, Maiden Surname)

Mary Jamison Robinson

19a. Informant's Name/Relationship (Type, Print)

Corinne Hairston

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2424 Portage Road; Silver Spring, Maryland 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven

Date

June 19, 1997

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

Barbara L. Salomon

22. Name and Address of Facility

Latney's Funeral Home, Inc.
3831 Georgia Avenue N.W.; Washington, DC 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiopulmonary arrest.

2 hrs.

Due to (or as a consequence of):

b. Severe Chronic Obstructive pulmonary disease.

10 years

Due to (or as a consequence of):

c. Cerebrovascular accident.

> 2 years

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Tracheostomy Tube

Gastrostomy Tube

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

John Robinson

29c. License number

D19609

29d. Date signed (Month, Day, Year)

June 13, 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAMAN R. TULI, 3503 PERRY STREET, MT. RAINIER, MD 20712

31. Date filed (Month, Day, Year)

JUN 27 1997

32. Registrar's Signature

John Robinson

State
Registrar

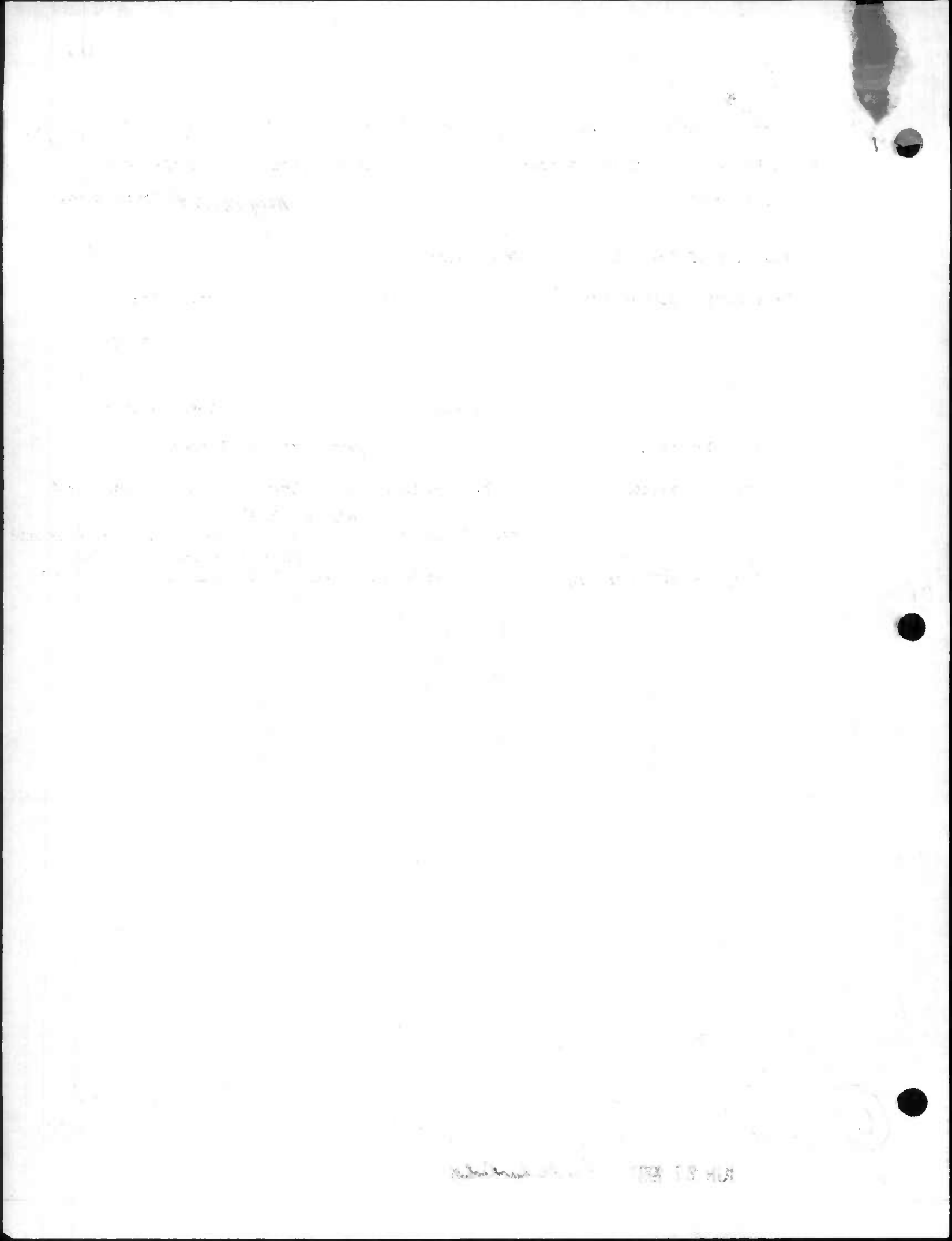
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21102

Certificate of Death

Reg. No.

Amended # 4, P.B. &c
7/2/97Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT

2. Date of Death

JUNE 20 1997

3. Time of Death

1:00 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George

5. Social Security Number

578-24-2655

6. Sex

M

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

December 5, 1919

9. Birthplace (State or Foreign Country)

Columbia, Va.

Usual Residence of Decedent

10e. State

MD

10b. County

Prince George

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

14200 Laurel Park Drive

10f. Zip Code

20707

10g. Citizen of What Country?

United States

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates: 1946-1961

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Retired Military

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Pleasant Ragland

18. Mother's Name (First, Middle, Maiden Surname)

Lurinda Ragland

19a. Informant's Name/Relationship (Type, Print)

Alma L. Ragland

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14738 Fourth St Laurel Maryland

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington National

Date

6-25-97

20c. Location - City or Town, State

Arlington Va.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Seward Mortuary Service

P.O. Box 5804 Capitol Heights, Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

BILATERAL PNEUMONIA

Approximate Interval Between Onset and Death

5 days

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Parkinson's Disease

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D 24721

29d. Date signed (Month, Day, Year)

6/20/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

SYED SADIQ, 14800, 4th St, Laurel, MD 20707

31. Date filed (Month, Day, Year)

JUN 25 1997

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

11-3-61 10:00 AM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

21103

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LEONARD ROSE				2. Date of Death Month JUNE Day 13 Year 1997		3. Time of Death FOUND 12:30 pm	
	4e. Facility Name (If not institution, give street and number) 3710 QUINCY ST.				4b. City, Town, or Location of Death BRENTWOOD		4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 235-36-7821		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) August 19, 1927	
	9. Birthplace (State or Foreign Country) West Virginia		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Brentwood	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) _____				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Director of Public Works		16b. Kind of Business/Industry City of Mount Rainier	
	17. Father's Name (First, Middle, Last) Robert Hamilton Rose				18. Mother's Name (First, Middle, Maiden Surname) Lora Virtle Shrewsberry			
	19a. Informant's Name/Relationship (Type, Print) Imogene R. Hyson - Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19225 Staleybridge Road, Germantown, Maryland 20876			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Blue Ridge Memorial Gardens		20c. Location - City or Town, State 06/20/97 Prosperity, WV	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
					28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier 				29c. License number DEPUTY MEDICAL EXAMINER D 33954		29d. Date signed (Month, Day, Year) JUNE 18, 1997	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARIO F. GOLLE JR MD 3001 HOSPITAL DRIVE, CHEVERLY MARYLAND 20785							
31. Date filed (Month, Day, Year) JUN 23 1997				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21104

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ruth Richardson				2. Date of Death Month Day Year June 16, 1997		3. Time of Death 8:15 A			
	4a. Facility Name (If not institution, give street and number) Pine View Nursing Home				4b. City, Town, or Location of Death Clinton		4c. County of Death Prince Georges			
Funeral Director	5. Social Security Number 577 01 3143		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		8. Date of Birth (Month, Day, Year) July 6, 1906		9. Birthplace (State or Foreign Country) New Jersey	
	Usual Residence of Decedent 10a. State Maryland 10b. County Prince George's 10c. City, Town or Location Clinton 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
To Be Completed by Funeral Director	10e. Street and Number Pineview Manor Nursing Home				10f. Zip Code 20735		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Telephone Operator				16b. Kind of Business/Industry AT&T	
	17. Father's Name (First, Middle, Last) Robert W. Callhan				18. Mother's Name (First, Middle, Maiden Surname) Pearl Schounhover					
To Be Completed by Physician/Medical Examiner	19e. Informant's Name/Relationship (Type, Print) Helen Grisson				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5513 Lod Street, San Diego, CA 92177					
	20e. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lee Crematory June 17, 1997		Date Clinton, Maryland		20c. Location - City or Town, State			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee [Signature]				22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Md					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): f. Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) 26. Piece of Death (Check only one) 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)									
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier John Van Dam M.D. 29c. License number D30583 29d. Date signed (Month, Day, Year) 6/17/97									
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) John Van Dam, M.D. 3508 Old Silver Hill Rd. Suitland, Md.									
State Registrar	31. Date filed (Month, Day, Year) JUL 02 1997				32. Registrar's Signature John Davidson Randall					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21105

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JAMES W. ROACH, Sr.				2. Date of Death Month Day Year JUNE 29-1997		3. Time of Death 5:18 PM	
	4a. Facility Name (If not institution, give street and number) SOUTHERN MARYLAND HOSPITAL				4b. City, Town, or Location of Death CLINTON		4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 228-36-2714		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 68		8. Date of Birth (Month, Day, Year) JUNE 12, 1929	
	9. Birthplace (State or Foreign Country) Virginia		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Clinton	
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 7619 Poplar Hill Lane		10f. Zip Code 20735		
10g. Citizen of What Country? U.S.A.		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1951- If Yes, Give Year or Dates: 1953		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Receiving Clerk		16b. Kind of Business/Industry Food Store		
17. Father's Name (First, Middle, Last) (Unknown) Roach				18. Mother's Name (First, Middle, Maiden Surname) Ellie Edwards				
19a. Informant's Name/Relationship (Type, Print) Mary Anne Roach (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7619 Poplar Hill Lane Clinton, Maryland 20735				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery		20c. Location - City or Town, State Clinton, Maryland		20d. Date July 3, 1997		
21. Signature of Funeral Service Licensee Dr. S. Smith				22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, Maryland 20735				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) cardiac arrhythmia Due to (or as a consequence of): coronary artery disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Status post triple coronary bypass surgery Due to (or as a consequence of):				Approximate Interval Between Onset and Death				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Dr. R. P. [Signature]		29c. License number D04358		29d. Date signed (Month, Day, Year) 6-30-1997		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Ben. Bengtson 9654 Mon 650 Pike UPRR Men 6502 MD 20772								
31. Date filed (Month, Day, Year) JUL 02 1997		32. Registrar's Signature John Davidson-Randall						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21106

Items:8 per FH,23b per MD G-750 8/14/97 dh

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Cleatus M. Starliper				2. Date of Death Month June Day 26 Year 1997		3. Time of Death 0909															
	4a. Facility Name (If not institution, give street and number) Washington Co. Hosp.				4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington															
Funeral Director	5. Social Security Number 204-30-5920		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) 8/21/18															
	9. Birthplace (State or Foreign Country) Pa.		10a. State Pa.		10b. County Franklin		10c. City, Town or Location Mercersburg															
Usual Residence of Decedent																						
10e. State Pa.			10f. Zip Code 17236			10g. Citizen of What Country? USA																
11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:																
14. Race - American Indian, Black, White, etc. Specify: White			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dairy and Fruit Farmer																
16b. Kind of Business/Industry Farming			17. Father's Name (First, Middle, Last) Charles M. Starliper			18. Mother's Name (First, Middle, Maiden Surname) Florence Pensinger																
19e. Informant's Name/Relationship (Type, Print) Mrs. Cecyl M. Starliper			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6963 Charles Twon Rd. Mercersburg, Pa. 17236																			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Fairview Cem.			20c. Location - City or Town, State Mercersburg Franklin Co., Pa.																
21. Signature of Funeral Service Licensee F. M. Lininger			22. Name and Address of Facility Lininger-Fries F. Home 47 N. Park Ave., Mercersburg, Pa. 17236																			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																						
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Acute myocardial Infarction</td> <td>Due to (or as a consequence of):</td> <td rowspan="4"> Approximate Interval Between Onset and Death </td> </tr> <tr> <td>b.</td> <td>Postoperative to coronary artery</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Acute myocardial Infarction	Due to (or as a consequence of):	Approximate Interval Between Onset and Death	b.	Postoperative to coronary artery	Due to (or as a consequence of):	c.		Due to (or as a consequence of):	d.		Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Acute myocardial Infarction	Due to (or as a consequence of):	Approximate Interval Between Onset and Death																		
	b.	Postoperative to coronary artery	Due to (or as a consequence of):																			
	c.		Due to (or as a consequence of):																			
	d.		Due to (or as a consequence of):																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. insulin dependent diabetes mellitus History of Hypertension, congestive heart failure and previous myocardial infarction						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown																
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No															
			28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)																
			28f. Location (Street and Number or Rural Route Number, City or Town, State)																			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Physician : To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner : On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																						
29b. Signature and title of certifier K. P. Riddle			29c. License number D38764			29d. Date signed (Month, Day, Year) 6/27/97																
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KARL P. RIDDLE, MD 1111 Medical Center Rd, Suite 100 Hagerstown MD 21742																						
31. Date filed (Month, Day, Year) JUL 10 1997			32. Registrar's Signature Julia Davidson-Randall																			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit certificate.

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21107

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) John Samuel Swann		2. Date of Death Month: June, Day: 27, Year: 1997		3. Time of Death 8:00 AM	
4a. Facility Name (If not institution, give street and number) 7620 MARSHALL'S CORNER ROAD			4b. City, Town, or Location of Death POMFRET		4c. County of Death CHARLES
5. Social Security Number 214-28-3910		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	8. Date of Birth (Month, Day, Year) FEB. 25, 1907	9. Birthplace (State or Foreign Country) MARYLAND
Usual Residence of Decedent					
10a. State MARYLAND		10b. County CHARLES		10c. City, Town or Location POMFRET	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 7620 MARSHALL'S CORNER ROAD		10f. Zip Code 20675	
10g. Citizen of What Country? UNITED STATES		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: AMERICAN INDIAN		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 3RD. GRADE College (1-4 or 5+):	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) FARMER		16b. Kind of Business/Industry FARMING		17. Father's Name (First, Middle, Last) JAMES SWANN	
18. Mother's Name (First, Middle, Maiden Surname) MAMIE PROCTOR SWANN		19a. Informant's Name/Relationship (Type, Print) ERMA THOMPSON / NIECE		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8868 SPARROW COURT, BEL ALTON, MARYLAND 20611	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):		20b. Place of Disposition (Name of cemetery, crematory or other place) ST. IGNATIUS CHURCH CEM.		20c. Location - City or Town, State 7/1/97 CHAPEL POINT, MARYLAND	
21. Signature of Funeral Service Licensee LINDA C. THORNTON JOHNSON M00583		22. Name and Address of Facility THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 730 yrs.	
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial fibrillation Hypertension Advanced age		23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify):	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier [Signature]	
29c. License number D-25992		29d. Date signed (Month, Day, Year) 6/27/97		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Khadar Baig, MD., 6620 Crain Highway, P.O. Box 190, La Plata, Maryland 20646	
31. Date filed (Month, Day, Year) JUL 01 1997		32. Registrar's Signature Julia Davidson Randall			

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21108

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Littleton J. Sterling				2. Date of Death Month Day Year June 22, 1997				3. Time of Death 1:23 p.m.	
	4a. Facility Name (If not institution, give street and number) Edw.W.McCreedy Memorial Hospital				4b. City, Town, or Location of Death Crisfield				4c. County of Death Somerset	
Funeral Director	5. Social Security Number 163-05-3000		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) October 4, 1908		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Somerset		10c. City, Town or Location Crisfield				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 3486 State Street				10f. Zip Code 21817		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4or 5+) H. S. Graduate 2 Years				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales			16b. Kind of Business/Industry Cutlery Mfg.		
	17. Father's Name (First, Middle, Last) Cornelius L. Sterling				18. Mother's Name (First, Middle, Maiden Surname) Edith Nelson					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Jimmie Lee Howard (Step-Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8351 Hilda Drive - Salisbury, MD 21804					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory		Date 6/24/97		20c. Location - City or Town, State Salisbury, MD			
	21. Signature of Funeral Service Licensee Robert H. Bradshaw, Jr.				22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, MD 21817					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Septic Shock</i> Due to (or as a consequence of): b. <i>Aspiration Pneumonia</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</i>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Charles Folashade M.D.</i>		29c. License number D50759		29d. Date signed (Month, Day, Year) 6/24/97				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) McREEDY HOSPITAL 210 HALL HIGHWAY CRISFIELD MD 21817										
31. Date filed (Month, Day, Year) JUN 25 1997		32. Registrar's Signature <i>John Anderson-Randall</i>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Glendon Blaine Sturgill, Sr.				2. Date of Death Month Day Year JUNE 29 1997		3. Time of Death 2:17 A	
	4a. Facility Name (If not institution, give street and number) LOGANS WHARF / SOUTH MAIN ST.				4b. City, Town, or Location of Death Port Deposit		4c. County of Death CECIL	
Funeral Director	5. Social Security Number 219-60-9337		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 43 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 22, 1953	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Cecil		10c. City, Town or Location Port Deposit	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 144 Principio Road		10f. Zip Code 21904		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Ten Years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Construction Worker		16b. Kind of Business/Industry Howery Contracting, Inc. North East, Maryland			
	17. Father's Name (First, Middle, Last) Cleveland Blaine Sturgill, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Mary Gillespie			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Cleveland B. Sturgill, Jr.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1423 Principio Furnace Road, Perryville, MD 21903			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Principio Cemetery		Date 7/3/97		20c. Location - City or Town, State Perryville, Maryland	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Theresa M. Patterson, Sr.</i>				22. Name and Address of Facility Lee A. Patterson & Son Funeral Home Perryville, Maryland 21903-0188			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. COCAINE AND NARCOTIC INTOXICATION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
					24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 6/29/97		28b. Time of Injury unknown M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred unknown				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Logan's Wharf			
	28f. Location (Street and Number or Rural Route Number, City or Town, State) S. Main Street, Cecil County							
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Theresa M. Patterson</i>			
	29c. License number O.C.M.E				29d. Date signed (Month, Day, Year) JUNE 29, 1997			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>THEODORE M. HAY</i> 111 Penn Street, Baltimore, Maryland 21201							
	31. Date filed (Month, Day, Year) JUL 01 1997				32. Registrar's Signature <i>John Davidson-Randall</i>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21110

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JAMES EDWIN SULLIVAN, JR.				2. Date of Death Month Day Year June 25, 1997		3. Time of Death 11:40PM			
	4a. Facility Name (If not institution, give street and number) VA Maryland Health Care System				4b. City, Town, or Location of Death Perry Point		4c. County of Death Cecil			
Funeral Director	5. Social Security Number 221-20-9723		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 62 Yrs.		8. Date of Birth (Month, Day, Year) JULY 7, 1934		9. Birthplace (State or Foreign Country) DELAWARE	
	Usual Residence of Decedent									
10a. State DE		10b. County NEW CASTLE		10c. City, Town or Location WILMINGTON				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 412 SOUTH SYCAMORE STREET				10f. Zip Code 19805		10g. Citizen of What Country? U.S.A.				
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 10/53 TO 7/55		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PRIVATE (MARINE)			16b. Kind of Business/Industry MILITARY			
17. Father's Name (First, Middle, Last) JAMES E. SULLIVAN, SR.					18. Mother's Name (First, Middle, Maiden Surname) TERESA HAGGERTY					
19a. Informant's Name/Relationship (Type, Print) JANE F. KEOUGH					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2403 DORVAL ROAD, WILMINGTON, DE 19810					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) ENTOMBMENT			20b. Place of Disposition (Name of cemetery, crematory or other place) CATHEDRAL CEMETERY			Date JUNE 28 1997		20c. Location - City or Town, State WILMINGTON, DE		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility MEALEY FUNERAL HOMES PO BOX 2866, WILMINGTON, DE 19805-0866					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Respiratory Failure Due to (or as a consequence of): b. Metastatic Bronchogenic Carcinoma Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 4 days 17 months										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 					29c. License number D20215		29d. Date signed (Month, Day, Year) 6/25/97			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) KARMACHANDRA NAIR, M.D. VA Maryland Health Care System, Perry Point, MD 21902										
31. Date filed (Month, Day, Year) JUN 26 1997		32. Registrar's Signature 								

SULLIVAN, James

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Name known to physician

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

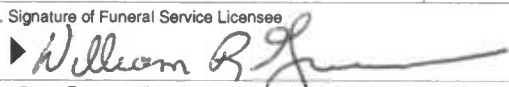
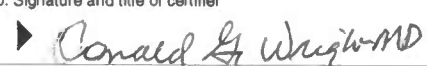
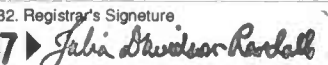
Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97 21111

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WALTER SCHULTZ				2. Date of Death Month Day Year JUNE 27, 1997		3. Time of Death 2:45 PM.			
	4e. Facility Name (If not institution, give street and number) 3909 6th. ST.				4b. City, Town, or Location of Death NORTH BEACH		4c. County of Death CALVERT CO.			
Funeral Director	5. Social Security Number 173 01 9823		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) Apr. 21, 1913			
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State Maryland		10b. County Calvert		10c. City, Town or Location North Beach			
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 3909 6th Street				10f. Zip Code 20714	
	10g. Citizen of What Country? USA				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1943-46	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: white				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+)	
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) auto body painter/repairman				16b. Kind of Business/Industry D.C. Fire Dept.				17. Father's Name (First, Middle, Last) Walter Schultz	
	18. Mother's Name (First, Middle, Maiden Surname) Helen Bonashivest				19e. Informant's Name/Relationship (Type, Print) Mrs. Mildred Schultz / wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as # 10 above	
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) MD Veterans Cemetery				20c. Location - City or Town, State 7-3-97 Cheltenham, MD	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. METASTATIC PROSTRATE CANCER	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? INSPECTION <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day Year)				28b. Time of Injury M		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		
29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JUNE 29, 1997				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Donald G. Wright M.D. 111 Penn Street, Baltimore, Maryland 21201				31. Date filed (Month, Day, Year) JUN 30 1997				32. Registrar's Signature 		

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Arteriosclerotic Cardiovascular Disease

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

21112

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Justin Ralph Sypher, Jr.				2. Date of Death Month June 18, 1997 Day Year		3. Time of Death 5:30 AM	
	4a. Facility Name (If not institution, give street and number) St. Mary's Nursing Center				4b. City, Town, or Location of Death Leonardtwn		4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 577-14-7701		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		8. Date of Birth (Month, Day, Year) May 30, 1907	
	9. Birthplace (State or Foreign Country) Pennsylvania							
To Be Completed by Funeral Director	Usual Residence of Decedent							
	10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location California		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 45398 Sypher Road				10f. Zip Code 20619		10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electronic Engineer		16b. Kind of Business/Industry Defense/U.S. Navy	
	17. Father's Name (First, Middle, Last) Justin Ralph Sypher, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Rhea Weatherwill Gumbs			
	19a. Informant's Name/Relationship (Type, Print) Jane Sypher, Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45211 Cove Manor Road, California, Maryland 20619			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State 6-18-1997 Alexandria, Virginia			
	21. Name and Address of Funeral Home Michael K. Blankenship, MD0852				22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, Maryland 20650-0279			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediata Cause (Final disease or condition resulting in death) a. Metastatic Lung Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Orogenic Bronchopneumonia stroke Pericardial effusion								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Physician : To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner : On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier David M. Federle				29c. License number D34198		29d. Date signed (Month, Day, Year) 1/19/97		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID M. FEDERLE MD 24035 THREE NOTCH RD. HOLLYWOOD, MD 20636								
31. Date filed (Month, Day, Year) 6-18-97				32. Registrar's Signature Johi Davidson-Randall				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21113

Amended Item#10e, 19b per FH G778 12/22/99 EW

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) Alexander Alley Smith, Jr.				2. Date of Death Month Day Year June 15, 1997		3. Time of Death 6:20 PM	
4a. Facility Name (If not institution, give street and number) 45775 Sherran Drive				4b. City, Town, or Location of Death Lexington Park		4c. County of Death St. Mary's	
5. Social Security Number 231-26-5862		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 70 Yrs.		8. Date of Birth (Month, Day, Year) May 5, 1927	
9. Birthplace (State or Foreign Country) Virginia		10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Lexington Park	
10d. Inside City Limits 1 Yes 2 No		10e. Street and Number 45775 Sherran Drive		10f. Zip Code 20653		10g. Citizen of What Country? United States	
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Aeronautical Engineer		16b. Kind of Business/Industry U.S. Government		17. Father's Name (First, Middle, Last) Alexander Alley Smith, Sr.	
18. Mother's Name (First, Middle, Maiden Surname) Helen Aubrey Vaughan		19a. Informant's Name/Relationship (Type, Print) Ethel J. Smith Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45775 Sherran Drive, Lexington Park, MD 20653			
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Date 6/17/97		20d. Location - City or Town, State Alexandria, Virginia	
21. Signature of Funeral Service Representative Edward N. Brinsfield, Jr.		22. Name and Address of Facility Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Esophageal Carcinoma Due to (or as a consequence of): Burnett's esophagus Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							
23b. Approximate Interval Between Onset and Death 1 year							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown							
24a. Was an autopsy performed? 1 Yes 2 No							
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No							
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)					
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier William K. Kelly MD - St Mary's Hosp.				29c. License number D39979		29d. Date signed (Month, Day, Year) 6/17/97	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) William K. Kelly MD - St Mary's Hosp. Leonardtown MD 20650							
31. Date filed (Month, Day, Year) JUN 17 1997				32. Registrar's Signature John Davidson-Randall			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21114

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ethel F. Seitz				2. Date of Death Month June Day 25 Year 1997		3. Time of Death 1:00PM	
	4a. Facility Name (If not institution, give street and number) 615 Streaker Road				4b. City, Town, or Location of Death Sykesville		4c. County of Death Carroll	
Funeral Director	5. Social Security Number 219-36-1824		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 9, 1923	
	9. Birthplace (State or Foreign Country) Virginia		10a. State MD		10b. County Carroll		10c. City, Town or Location Sykesville	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 615 Streaker Road		10f. Zip Code 21784		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurses Aide		16b. Kind of Business/Industry Health Care				
17. Father's Name (First, Middle, Last) Irvin Lee Divers				18. Mother's Name (First, Middle, Maiden Surname) Geneva Ann Powell				
19a. Informant's Name/Relationship (Type, Print) Mr. Stewart P. Seitz, Sr.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 615 Streaker Road Sykesville, MD 21784				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lake View Mem. Park		20c. Location - City or Town, State 6/28/97 Sykesville, MD				
21. Signature of Funeral Service Licensee Brian A. Haight				22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL (Box 195) Sykesville, MD 21784 (410)-795-1400				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Pancreatic Adenocarcinoma Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier M.M. Seitz M.D.				29c. License number D 33681		29d. Date signed (Month, Day, Year) 6/26/97		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. McEvoy, SYKESVILLE MD 21784								
31. Date filed (Month, Day, Year) JUN 26 1997				32. Registrar's Signature John Andrew Randall				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Savilia E. Shaffer

2. Date of Death

Month Day Year
June 24, 1997

3. Time of Death

1920

Funeral
Director

4a. Facility Name (If not institution, give street and number)

1414 N. Main St.

4b. City, Town, or Location of Death

Hampstead

4c. County of Death

Carroll

5. Social Security Number

215-58-3663

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
9/21/22

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Hampstead

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1414 N. Main St.

10f. Zip Code

21074

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Food preparation

16b. Kind of Business/Industry

School cafeteria

17. Father's Name (First, Middle, Last)

Charles Naylor

18. Mother's Name (First, Middle, Maiden Surname)

Daisy Burris

19a. Informant's Name/Relationship (Type, Print)

Dianna Shaffer- Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

84 East Padonia Rd. Timonium, MD 21093

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Falls Rd, United Meth.

Date

6/28/97

20c. Location - City or Town, State

Butter, MD.

21. Signature of Funeral Service Licensee

Steven W. Eline

22. Name and Address of Facility

Eline Funeral Home 934 S. Main St

Hampstead, MD 21074

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. VENTRICULAR FIBRILLATION

Due to (or as a consequence of):

b. Atherosclerotic Heart Disease

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Instant

8 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Colin E. Hagan

29c. License number

D18200

29d. Date signed (Month, Day, Year)

6/28/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

CHRISTOPHER M. GARDNER 700 A POOLE RD WESTMINSTER MD 21157

State
Registrar

31. Date filed (Month, Day, Year)

JUN 26 1997

32. Registrar's Signature

R. Anderson-Randall

Baltimore, Maryland 21215-0020
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21116

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Melvin F. Swanke

2. Date of Death

Month

Day

Year

JUNE 15, 1997

3. Time of Death

00:45AM

4a. Facility Name (If not institution, give street and number)

9822 WASHINGTON BOULEVARD

4b. City, Town, or Location of Death

LAUREL

4c. County of Death

HOWARD

Funeral
Director

5. Social Security Number

277-34-8245

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

56 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 14 1941

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

(transient)

10c. City, Town or Location

(transient)

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

(transient)

10f. Zip Code

(transient)

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

salesman

16b. Kind of Business/Industry

retail

17. Father's Name (First, Middle, Last)

Melvin F. Swanke Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Frances Belbin

19a. Informant's Name/Relationship (Type, Print)

Richard B. Swanke, brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1382 Alison Court, Westminster, MD 21158

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery

Date

6/26/97

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Kathleen Pitts - Switzer

22. Name and Address of Facility

Pritts Funeral Home & Chapel

412 Washington Rd., Westminster, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

Hanging

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

SCENE

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☒ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

6-14-97

28b. Time of Injury

UNK M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Subject hanged self

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

MOTEL

28f. Location (Street and Number or Rural Route Number, City or Town, State)

9822 Washington Blvd. Rm 30

29a. Certifier

(Check one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. Laron Locke M.D.

29c. License number

OCME

29d. Date signed (Month, Day, Year)

JUNE 15, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUN 26 1997

32. Registrar's Signature

J. Laron Locke

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

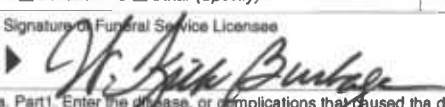

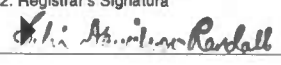
State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21117

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM ANTHONY STEGER, SR.				2. Date of Death Month 7 Day 1 Year 97		3. Time of Death 1445	
	4a. Facility Name (If not institution, give street and number) Atlantic General Hospital				4b. City, Town, or Location of Death Berlin		4c. County of Death Worcester	
Funeral Director	5. Social Security Number 219-01-4924		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) 4/23/21	
	9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County Worcester		10c. City, Town or Location Ocean City	
Usual Residence of Decedent								
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
10e. Street and Number 211 St. Louis Ave.								
10f. Zip Code 21842								
10g. Citizen of What Country? USA								
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: white								
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Storekeeper				16b. Kind of Business/Industry Marine Supply
17. Father's Name (First, Middle, Last) William Anthony Steger				18. Mother's Name (First, Middle, Maiden Surname) Veronica Buda				
19a. Informant's Name/Relationship (Type, Print) Violet Steger / Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 211 St. Louis Ave. Ocean City, MD 21842				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Evergreen Cemetery			20c. Date 7/3/97		20d. Location - City or Town, State Berlin, MD
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Burbage Funeral Home 108 William St. Berlin, MD 21811				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. mesothelioma Due to (or as a consequence of): b. asbestosis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Approximate Interval Between Onset and Death 14 years 2 weeks								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
				28d. Describe how Injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 		29c. License number D47676		29d. Date signed (Month, Day, Year) 7/1/97
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bsher Touleimat, MD 9733 Healthway Dr. Berlin, MD 21811								
31. Date filed (Month, Day, Year) JUL 02 1997				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible **9721118**
 State of Maryland / Department of Health and Mental Hygiene
 Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ralph H. Story						2. Date of Death Month Day Year June 18, 1997		3. Time of Death 10:45 P.M.		
	4a. Facility Name (If not institution, give street and number) Prince George's General Hospital						4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 231 32 3372		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 31, 1924		9. Birthplace (State or Foreign Country) Virginia		
	Usual Residence of Decedent										
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Bowie				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 2812 Federal Lane				10f. Zip Code 20715		10g. Citizen of What Country? United States					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter			16b. Kind of Business/Industry Union				
17. Father's Name (First, Middle, Last) Alphens Story						18. Mother's Name (First, Middle, Maiden Surname) Fannie Clore					
19a. Informant's Name/Relationship (Type, Print) Ralph W. Story Son						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13100 Bowie Station Court Bowie Maryland 20715					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Wilderness Baptist Church Cemetery Spotsylvania Co. Va.		20c. Location - City or Town, State June 22, 1997					
21. Signature of Funeral Service Licensee <i>Michael L. Bigler</i>						22. Name and Address of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Md. 20715					
23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MYOCARDIAL INFARCTION Due to (or as a consequence of): b. CORONARY ARTERY DISEASE Due to (or as a consequence of): c. HYPERCHOLESTEROLEMIA Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death 2 DAYS 5 YEARS 10 YEARS	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
				28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <i>Michael L. Bigler MD</i>				29c. License number D50343		29d. Date signed (Month, Day, Year) JUNE 19, 1997					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 3231 SUPERIOR LANE A-6, BOWIE, MARYLAND 20715											
31. Date filed (Month, Day, Year) JUN 24 1997				Registrar's Signature <i>John Anderson</i>							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21119

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HUNTER L. STONE, JR.				2. Date of Death Month Day Year June 19, 1997		3. Time of Death 10:10 A.M.		
	4a. Facility Name (If not Institution, give street and number) Bowie Health Care Center				4b. City, Town, or Location of Death Bowie		4c. County of Death Prince Georges		
Funeral Director	5. Social Security Number 243 48 3513		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 60 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 8, 1937		
	9. Birthplace (State or Foreign Country) North Carolina		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Bowie		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 12402 Shelter Lane		10f. Zip Code 20715		10g. Citizen of What Country? United States	
11. Marital Status 1 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Supervisor		16b. Kind of Business/Industry Department of Defense					
17. Father's Name (First, Middle, Last) Hunter L. Stone Sr.				18. Mother's Name (First, Middle, Maiden Surname) Wilna Dick					
19a. Informant's Name/Relationship (Type, Print) Barbara L. Stone Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12402 Shelter Lane Bowie Maryland 20715					
20a. Method of Disposition 1 <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory June 20, 1997 Alexandria, Va		20c. Location - City or Town, State					
21. Signature of Funeral Service Licensee		22. Name and Address of Facility Evans Funeral Home Inc 16000 Annapolis Rd Bowie, Md 20715							
23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death)								1.5 yr	
Due to (or as a consequence of):								~ 10 yrs	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								6 mo	
Due to (or as a consequence of):								6 mo	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
Hypertension									
Pancreatic pseudocyst									
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and Title of Certifier		29c. License number D18010		29d. Date signed (Month, Day, Year) 6/20/97			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Kenneth L. Baugmann Bethesda 536 Johns Hopkins									
31. Date filed (Month, Day, Year) JUN 24 1997		32. Registrar's Signature John Davidson Carroll							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item 1 7-15-97 Film G749 W.H. Per Doctor

Certificate of Death

Reg. No.

21120

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Albert Lee St. Clair				2. Date of Death Month Day Year June 25, 1997		3. Time of Death 7:30 a.m.	
	4a. Facility Name (If not institution, give street and number) 5402 Morton Place				4b. City, Town, or Location of Death Riverdale		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 216-30-2573		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 63 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 14, 1933	
	9. Birthplace (State or Foreign Country) Washington, DC		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Riverdale	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 5402 Morton Place		10f. Zip Code 20737	
	10g. Citizen of What Country? U.S.A.				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) -----	
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter				16b. Kind of Business/Industry Carpenter/Self			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) William Gordon St. Clair				18. Mother's Name (First, Middle, Maiden Surname) Mary Elizabeth Robey			
	19a. Informant's Name/Relationship (Type, Print) Daisy P. Stanton - Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5402 Morton Place, Riverdale, Maryland 20737			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		20c. Location - City or Town, State 06/30/97 Suitland, Maryland	
	21. Signature of Funeral Service Licensee Claudette J. Gasch				22. Name and Address of Facility Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Carcinoma of lung with cerebral metastases Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death months			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred			
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Frederick H. Wilhelm			
To Be Completed by Physician/Medical Examiner	29c. License number D 10226				29d. Date signed (Month, Day, Year) June 25, 1997			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Frederick H. Wilhelm, M.D. 5807 Annapolis Road, Hyattsville, Maryland 20784-1201				31. Date filed (Month, Day, Year) JUN 27 1997			
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature John A. Anderson				33. Registrar's Title Registrar			
	34. State Registrar's Office State Registrar				35. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21121

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BOOKER THOMAS SMALLEY, SR.				2. Date of Death Month: June Day: 24 Year: 1997		3. Time of Death 4:23pm	
	4a. Facility Name (If not institution, give street and number) Physicians Memorial Hospital				4b. City, Town, or Location of Death La Plata		4c. County of Death Charles	
Funeral Director	5. Social Security Number 227 225 989	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min.	8. Date of Birth (Month, Day, Year) Mar. 6, 1904		9. Birthplace (State or Foreign Country) Lincoln Co., GA
	Usual Residence of Decedent							
10a. State District of Columbia		10b. County Washington		10c. City, Town or Location Washington		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10a. Street and Number 4206 East Capitol Street, N. E.				10f. Zip Code 20019		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Retired Lawyer		16b. Kind of Business/Industry Government/Self Employed		
17. Father's Name (First, Middle, Last) Ulyssis Smalley				18. Mother's Name (First, Middle, Maiden Surname) Lula Thomas				
19a. Informant's Name/Relationship (Type, Print) Booker T. Smalley, Jr. - Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4213 Sandwich Circle, Waldorf, Maryland 20601				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery		Data 7/1/97		20c. Location - City or Town, State Brentwood, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility STEWART FUNERAL HOME, Inc. 4001 Benning Road, N. E., Washington, D. C. 20601				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. Urosepsis Due to (or as a consequence of):</p> <p>b. Respiratory failure Due to (or as a consequence of):</p> <p>c. Urinary tract infection Due to (or as a consequence of):</p> <p>d. </p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate interval Between Onset and Death</p> <p>2 weeks</p> </div> </div> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number D46246		29d. Date signed (Month, Day, Year) June 25 1997		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ashraf M. Meelu, MD Southern Maryland Oncology, #2 St. Patrick Drive, Waldorf, Maryland 20603								
31. Date filed (Month, Day, Year) JUN 27 1997		32. Registrar's Signature 						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21122

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Thomas Ronald Scott

2. Date of Death

Month Day Year
June 28, 1997

3. Time of Death

3:23 AM

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

577-68-8111

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

46 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug 18, 1950

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Waldorf

10d. Inside City Limits

1 ☐ Yes ☒ No

10a. Street and Number

1922 Michael Road

10f. Zip Code

20601

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

Self Employed

16b. Kind of Business/Industry

Car Dealership

17. Father's Name (First, Middle, Last)

Thomas Reed Scott

18. Mother's Name (First, Middle, Maiden Surname)

Virginia DeV Vaughn

19a. Informant's Name/Relationship (Type, Print)

Brenda M. Scott

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1922 Michael Rd, Waldorf, Maryland 20601

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Trinity Memorial Gardens

20c. Location - City or Town, State

Waldorf, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Free Funeral Home, Inc 6633
Old Alexandria Ferry Rd, Clinton, MD 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Vertical banded gastroplasty - Gastric leakage.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Morbid obesity - cardio-respiratory failure - sepsis

Due to (or as a consequence of):

c. Renal Failure.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D28639

29d. Date signed (Month, Day, Year)

June 28, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jacques Zephirin, MD 2955 Crain Hwy St F, Waldorf, Md

31. Date filed (Month, Day, Year)

JUL 02 1997

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State of Maryland / Department of Health and Mental Hygiene 97 21123

Reg. No.

DHHM 16 Rev 6/95

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97 21124

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) SARAH SUTHERLAND TAYLOR				2. DATE OF DEATH MONTH DAY YEAR June 20, 1997		3. TIME OF DEATH 7:00 A.M.	
4. SOCIAL SECURITY NUMBER 131-28-1714		5. SEX 1 M 2 F		6. AGE (In yrs. last birthday) 58 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 16, 1938	
9a. FACILITY NAME (If not institution, give street and number) 23621 Cemetery Road				9b. CITY, TOWN OR LOCATION OF DEATH Chance		9c. COUNTY OF DEATH Somerset	
10a. STATE Maryland				10b. COUNTY Somerset		10c. CITY, TOWN OR LOCATION Chance	
10d. INSIDE CITY LIMITS? 1 YES 2 NO				10e. STREET AND NUMBER 23621 Cemetery Road			
10f. ZIP CODE 21816				10g. CITIZEN OF WHAT COUNTRY? U.S.			
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 3.5				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE		16b. KIND OF BUSINESS/INDUSTRY OWN HOME	
17. FATHER'S NAME (First, Middle, Last) WILLIAM ROGERS				18. MOTHER'S NAME (First, Middle, Maiden Surname) HELEN ROGERS			
19a. INFORMANT'S NAME (Type/Print) JOSEPH FRANK TAYLOR/HUSBAND				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23621 CEMETERY ROAD, CHANCE, MD. 21816			
20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SALISBURY CREMATORY		DATE 6/23/97		20c. LOCATION — City or Town, State SALISBURY, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> M00295				22. NAME AND ADDRESS OF FACILITY HINMAN FUNERAL HOME 11673 SOMERSET AVE., PRINCESS ANNE, MD. 21853			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CORONARY OCCLUSION Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST UNCONTROLLED DIABETES MELLITUS						Approximate Interval Between Onset and Death MINUTES 7 PM	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)					
27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D02556		29d. DATE SIGNED (Month, Day, Year) 6/23/97	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jesus G. Santiano M.D. 100 8th Street Pocomoke City, MD 21851							
31. DATE FILED (Month, Day, Year) JUN 24 1997				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

97 21125

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Mildred T. Thompson</i>					2. Date of Death Month <i>6</i> Day <i>29</i> Year <i>97</i>		3. Time of Death <i>0720</i>		
	4a. Facility Name (If not institution, give street and number) <i>MedPointe Continuing Care Facility</i>					4b. City, Town, or Location of Death <i>Elkton</i>		4c. County of Death <i>Cecil</i>		
Funeral Director	5. Social Security Number <i>222-14-4462</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>77</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>12-29-19</i>		9. Birthplace (State or Foreign Country) <i>Wilmington, DE</i>	
	Usual Residence of Decedent									
10a. State <i>Delaware</i>			10b. County <i>New Castle</i>		10c. City, Town or Location <i>Newark</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <i>2213 South College Avenue</i>					10f. Zip Code <i>19702</i>			10g. Citizen of What Country? <i>US</i>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		
15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i>			16b. Kind of Business/Industry <i>Own Home</i>		
17. Father's Name (First, Middle, Last) <i>Chester R. Jones</i>					18. Mother's Name (First, Middle, Maiden Surname) <i>Beatrice King</i>					
19a. Informant's Name/Relationship (Type, Print) <i>Charles E. Thompson, Jr.</i>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2213 South College Avenue, Newark, DE 19702</i>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Gracelawn Memorial Park</i>			20c. Location - City or Town, State <i>7-2-97 New Castle, Delaware</i>				
21. Signature of Funeral Service Licensee <i>[Signature]</i>					22. Name and Address of Facility <i>Beeson Memorial Services 2053 Pulaski Hwy., Newark, DE 19702</i>					
23a. Pertinent disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death) <i>Renal Failure</i></p> <p>Due to (or as a consequence of): <i>Congestive Heart Failure</i></p> <p>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>Ischemic Cardiomyopathy</i></p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate interval Between Onset and Death</p> <p><i>1 yr</i></p> <p><i>4 mo</i></p> <p><i>1 yr</i></p> </div> </div>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>[Signature]</i>					29c. License number <i>D43198</i>		29d. Date signed (Month, Day, Year) <i>6/30/97</i>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>James S. Ley, M.D. 901 Warburton Road, Elkton, MD 21921</i>										
31. Date filed (Month, Day, Year) <i>JUL 01 1997</i>					32. Registrar's Signature <i>[Signature]</i>					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 21126**
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Alice Derrickson West Trone						2. Date of Death Month Day Year June 20, 1997		3. Time of Death 7:00 AM	
	4a. Facility Name (If not institution, give street and number) 103 Park Circle						4b. City, Town, or Location of Death Elkton		4c. County of Death Cecil	
Funeral Director	5. Social Security Number 216-24-2362		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 91 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 28, 1905		9. Birthplace (State or Foreign Country) Delaware	
	Usual Residence of Decedent									
10a. State Md.		10b. County Cecil		10c. City, Town or Location Elkton				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street end Number 103 Park Circle				10f. Zip Code 21921				10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 3				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Registered Nurse				16b. Kind of Business/Industry Medical		
17. Father's Name (First, Middle, Last) Charles Elwood West						18. Mother's Name (First, Middle, Maiden Surname) Mary Margaret Derrickson				
19a. Informant's Name/Relationship (Type, Print) Susan R. Trone, Daughter						19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 103 Park Circle, Elkton, Md. 21921				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Gilpin Manor Mem. Pk. 6/24/97				20c. Location - City or Town, State Elkton, Md.		
21. Signature of Funeral Service Licensed 				22. Name and Address of Facility 259 E. Main Street, Elkton, Md. 21921 Gee Funeral Home						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Coronary Artery Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death years										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
				28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
				28f. Location (Street end Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier Monte Makous, MD				29c. License number D-44783				29d. Date signed (Month, Day, Year) June 23, 1997		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MONTE MAKOUS, MD 111 WEST HIGH STREET, ELKTON, MD 21921										
31. Date filed (Month, Day, Year) JUN 25 1997				32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 800.858.8888.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21127

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARIE THOMAS				2. Date of Death Month Day Year JUNE 25, 1997				3. Time of Death 00:45	
	4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital				4b. City, Town, or Location of Death Prince Frederick				4c. County of Death Calvert	
Funeral Director	5. Social Security Number 217-36-6763		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 63 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) Dec. 26, 1933		9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Calvert		10c. City, Town or Location Huntingtown	
To Be Completed by Funeral Director	Usual Residence of Decedent									
	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 155 Kyler Road		10f. Zip Code 20639		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates;		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Custodian				16b. Kind of Business/Industry Apartments			
	17. Father's Name (First, Middle, Last) James Owen Holland				18. Mother's Name (First, Middle, Maiden Surname) Ethel Gladys Thomas					
	19a. Informant's Name/Relationship (Type, Print) Madeline Jones/Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5418 Gallatin St. Hyattsville, MD 20781					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Edmonds UMC Cem.		Date 6/30/97		20c. Location - City or Town, State Chesapeake Beach, MD			
	21. Signature of Funeral Service Licensee Blacks & Sewell				22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Excessive Melancholia Due to (or as a consequence of): 20 to carcinoma of R. Breast Due to (or as a consequence of): R. Breast Due to (or as a consequence of):									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
Physician /Medical Examiner	23c. Approximate Interval Between Onset and Death									
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
State Registrar	29b. Signature and Title of certifier Dr. Issam Damalouji				29c. License number D03077				29d. Date signed (Month, Day, Year) 6-25-97	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Issam Damalouji M.D. Prince Frederick MD 20678									
31. Date filed (Month, Day, Year) JUN 27 1997		32. Registrar's Signature Jahia Davidson-Randall								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Figure 1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William Adrian Tate

2. Date of Death

Month Day Year
June 20, 1997

3. Time of Death

18:29

4e. Facility Name (If not institution, give street and number)

Calvert Memorial Hospital

4b. City, Town, or Location of Death

Prince Frederick

4c. County of Death

Calvert

Funeral
Director

5. Social Security Number

578-56-4038

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

54 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sep. 8, 1942

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Calvert

10c. City, Town or Location

Dunkirk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4101 Overlook Court

10f. Zip Code

20754

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
White15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Computer Technical Engineer

16b. Kind of Business/Industry

IBM

17. Father's Name (First, Middle, Last)

(Unknown) Tate

18. Mother's Name (First, Middle, Maiden Summa)

Margaret Tate

19a. Informant's Name/Relationship (Type, Print)

Marguerite A. Tate/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4101 Overlook Court Dunkirk, Maryland 20754

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Lee Crematory

Date

June

20c. Location - City or Town, State

Clinton, Maryland

21. Signature of Funeral Service Licensee

▶ S. F. S. J.

22. Name and Address of Facility

Lee Funeral Home Calvert, P.A.
8125 So. Md. Blvd. Owings, Maryland 2073623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Acute MI

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

MINUTES

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

{

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Medical ExaminerCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

▶ Charles Judge

29c. License number

D29657

29d. Date signed (Month, Day, Year)

June 21/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles Judge 120 Hospital Road #200 Prince Frederick, Maryland 20678

State
Registrar

31. Date filed (Month, Day, Year)

JUN 24 1997

32. Registrar's Signature

▶ John Davidson Randall

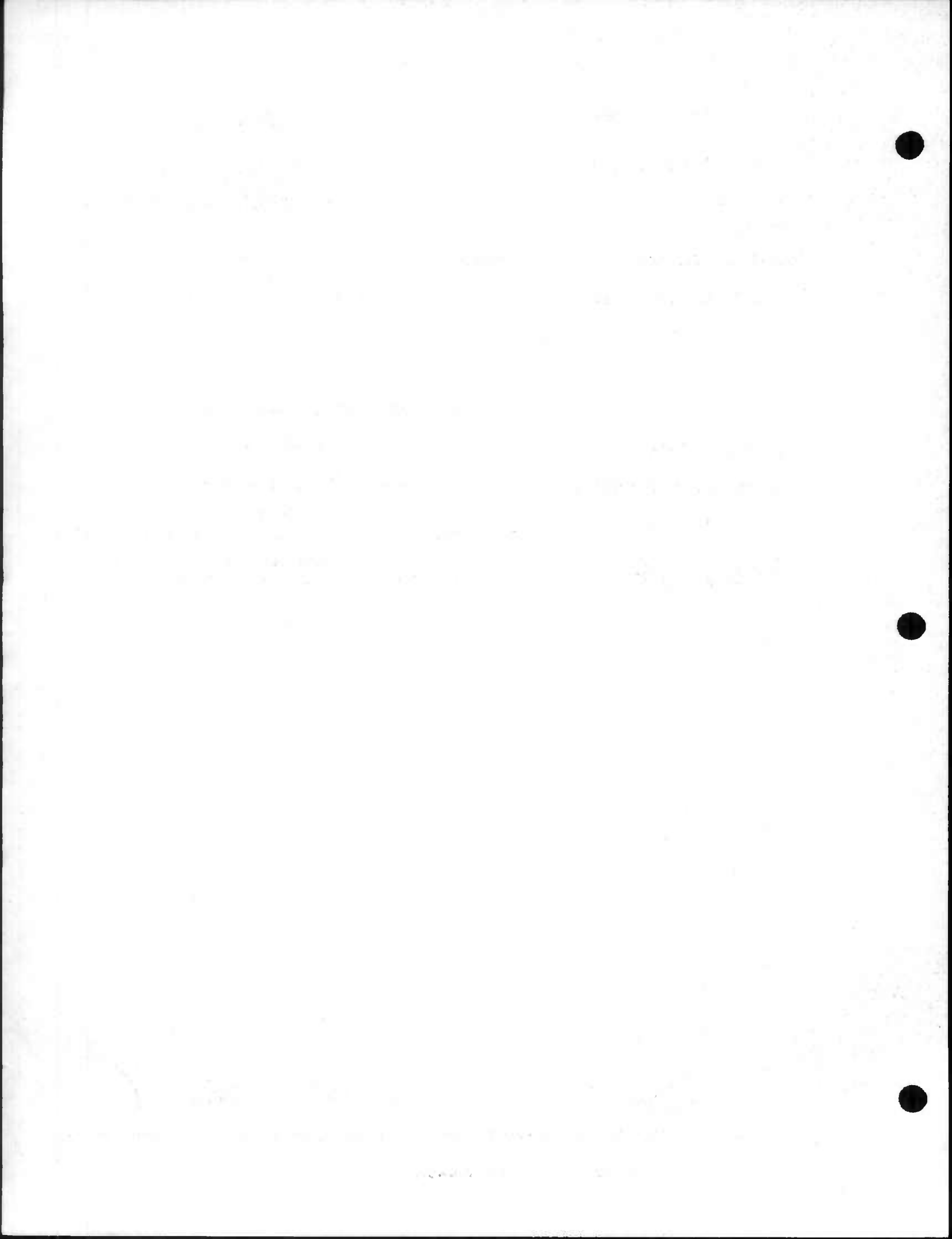
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21129

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Gater Thomas

2. Date of Death

June 17, 1997

3. Time of Death

2000

4a. Facility Name (If not institution, give street and number)

Calvert Memorial Hospital

4b. City, Town, or Location of Death

Prince Frederick

4c. County of Death

Calvert

5. Social Security Number

220-16-9149

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 18, 1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Calvert

10c. City, Town or Location

Prince Frederick

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

330 Arthur King Road

10f. Zip Code

20678

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
5

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Louis

Thomas, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Charlotte

Purvey

19a. Informant's Name/Relationship (Type, Print)

Lowell Thomas/Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 702 Prince Frederick, MD 20678

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Solid Rock Chr. Cemetery

Date

6/21/97

20c. Location - City or Town, State

Port Republic, MD

21. Signature of Funeral Service Licensee

Bladys A. Sewell

22. Name and Address of Facility

Sewell Funeral Home

1451 Dares Beach Rd. Prince Frederick, MD 20678

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Chronic Renal Failure

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

One year

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery disease, CHF,
Peripheral vascular disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury et
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Zahir Yousof M.D.

29c. License number

D27189

29d. Date signed (Month, Day, Year)

6/18/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ZAHIR YOUSAF M.D. Po Box 1289, WALDORF, MD. 20604

31. Date filed (Month, Day, Year)

JUN 19 1997

32. Registrar's Signature

Julia Swanson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Page 1 of 1

Page 1 of 1

Page 1 of 1

Page 1 of 1

Page 1 of 1

Page 1 of 1

Page 1 of 1

Page 1 of 1

Page 1 of 1

Page 1 of 1

Page 1 of 1

Page 1 of 1

Page 1 of 1

Page 1 of 1

Page 1 of 1

Page 1 of 1

Page 1 of 1

Page 1 of 1

Page 1 of 1

Page 1 of 1

Page 1 of 1

Page 1 of 1

Page 1 of 1

Page 1 of 1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21130

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carolyn Sue Tayman				2. Date of Death Month Day Year May 27, 1997		3. Time of Death 1:04 PM	
	4a. Facility Name (If not institution, give street and number) 41328 Delabrook Road				4b. City, Town, or Location of Death Mechanicsville		4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 216-40-7774		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 59 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 19, 1938	9. Birthplace (State or Foreign Country) Washington, D.C.
	Usual Residence of Decedent							
10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Mechanicsville			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 41328 Delabrook Road				10f. Zip Code 20659		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bartender		16b. Kind of Business/Industry		
17. Father's Name (First, Middle, Last) William Lawrence Shipp				18. Mother's Name (First, Middle, Maiden Surname) Rose Ford				
19a. Informant's Name/Relationship (Type, Print) John Lawrence Jones/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 605 Wilson Lane, Waldorf, MD 20602				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) MD Veterans Cemetery		20c. Location - City or Town, State Cheltenham, Maryland		
21. Signature of Funeral Service Licensee Michael R. Gardiner				22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Coronary Artery Disease Due to (or as a consequence of): b. Left Ventricular Failure Due to (or as a consequence of): c. Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death 10 yrs. 5 yrs. 5 yrs.
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Smoker.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier N-K. Jayaraman MD		29c. License number D 313 44		29d. Date signed (Month, Day, Year) May 28, 1997
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Nilima Jayaraman, M.D. 28227 Three Notch Rd., Mechanicsville, MD 20659								
31. Date filed (Month, Day, Year) JUN 02 1997				32. Registrar's Signature John A. Davidson				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

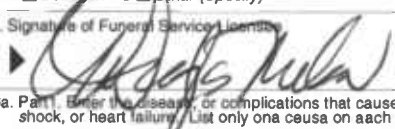
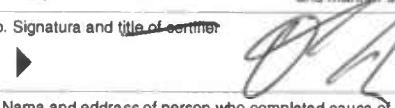
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

77 21131

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROBERT L. TURNER				2. Date of Death Month Day Year JUNE 23, 1997		3. Time of Death 2015PM	
	4a. Facility Name (If not institution, give street and number) BWI AIRPORT-BLUE LOT ROW FF				4b. City, Town, or Location of Death ODENTON		4c. County of Death ANNE ARUNDEL	
Funeral Director	5. Social Security Number 222-18-0808		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 67 Yrs.		8. Date of Birth (Month, Day, Year) JAN. 27, 1930	
	9. Birthplace (State or Foreign Country) PORTLAND, OREGON		10a. State DELAWARE		10b. County SUSSEX		10c. City, Town or Location MILLSBORO	
Usual Residence of Decedent								
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
10e. Street and Number 33 KNOLLWAY (MARINER'S COVE)								
10f. Zip Code 19966								
10g. Citizen of What Country? USA								
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: WHITE			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) _____					
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) AIR CONDITION & HEATING ENGINEER HEATING						16b. Kind of Business/Industry AIR CONDITION & HEATING		
17. Father's Name (First, Middle, Last) CHARLES L. TURNER						18. Mother's Name (First, Middle, Maiden Summa) SARAH ARMSTRONG		
19a. Informant's Name/Relationship (Type, Print) CATHERINE TURNER, WIFE						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33 KNOLLWAY (MARINER'S COVE), MILLSBORO, DE 19966		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) HENLOPEN MEMORIAL PARK 6/27/97			20c. Location - City or Town, State MILTON, DELAWARE		
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility MELSON FUNERAL SERVICES, LTD. LONG NECK RD., MILLSBORO, DELAWARE 19966		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular disease Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? Perished <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) AT SCENE		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)			28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28d. Describe how injury occurred		
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 						29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JUNE 24, 1997
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) JUN 26 1997						32. Registrar's Signature 		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

IRENE
TURPIN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21132

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Irene Virginia Turpin				2. Date of Death Month Day Year JUNE 28 1997		3. Time of Death 4:25 P.M.	
	4a. Facility Name (If not institution, give street and number) 32403 OVERHOLT ROAD				4b. City, Town, or Location of Death POCOMOKE CITY		4c. County of Death SOMERSET	
Funeral Director	5. Social Security Number 214-32-6370	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 70	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 3-2, 1927	9. Birthplace (State or Foreign Country) MD.	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD.	10b. County Somerset	10c. City, Town or Location Pocomoke City			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 32738 Rehobeth Rd.			10f. Zip Code 21851		10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 7th Grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Labera Nursery		16b. Kind of Business/Industry Bountful Ridge			
	17. Father's Name (First, Middle, Last) James Turner			18. Mother's Name (First, Middle, Maiden Surname) Louvie King Turner				
	19a. Informant's Name/Relationship (Type, Print) Helen A. Hitch Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32738 Rehobeth Rd. Pocomoke Md. 21851				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Christ M.E. Centery		20c. Location - City or Town, State 7-7-97 Pocomoke City, Md.			
	21. Signature of Funeral Service Licensee		22. Name and Address of Facility Savage Funeral Home 3812 Davis Rd. New Church, Va. 23415					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. stab wound of chest Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 6/18/97		28b. Time of Injury 10:00 PM		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) home		28d. Describe how injury occurred Subject stabbed				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Theodore M. King		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JUNE 29, 1997		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) JUL 01 1997		32. Registrar's Signature John Anderson-Randall						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 21133**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William Edward Thomas

2. Date of Death

Month Day Year
June 24, 1997

3. Time of Death

10:15 A

4a. Facility Name (If not institution, give street and number)

Charlotte Hall Veterans Home

4b. City, Town, or Location of Death

Charlotte Hall

4c. County of Death

St. Mary's

5. Social Security Number

078 16 7451

6. Sex

☒ M ☐ F

7. Age (in yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

June 22, 1920 Pa.

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

10d. Inside City Limits

Maryland Prince George's Temple Hills

10e. Street and Number

3705 Spring Terrace

10f. Zip Code

20748

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

☒ Yes ☐ No
If Yes, Give Year of Dates: WW
II13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4 or 5+)
216. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Field Maintenance

16b. Kind of Business/Industry

Cival Service

17. Father's Name (First, Middle, Last)

William Thomas

18. Mother's Name (First, Middle, Maiden Surname)

Alice Plank

19a. Informant's Name/Relationship (Type, Print)

Pauline G. Thomas

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3705 Spring Terrace, Temple Hills, MD 20748

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Maryland Veterans Cemetery

20c. Location - City or Town, State

Cheltenham, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Lee Funeral Home, Inc 6633
Old Alexandria Ferry Rd, Clinton, Md 2073523a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e. Sub Dural Hematoma

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Skull Fracture

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's Disease

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide

28e. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

K HADAR BAIG

18N 310 Hwy, Box 190, LaPlata, Md 20646

31. Date filed (Month, Day, Year)

JUL 02 1997

32. Registrar's Signature

Shirley Anderson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

William E. Thomas 6/24 @ 10:15A

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21134

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Aquilla Toliver				2. Date of Death Month Day Year 6/16/97		3. Time of Death 8:30pm	
	4a. Facility Name (If not institution, give street and number) Mariner Health Of Southern Md				4b. City, Town, or Location of Death Clinton		4c. County of Death Prince Georges	
Funeral Director	5. Social Security Number 578-50-8997		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 91 Yrs.		8. Date of Birth (Month, Day, Year) 4/23/06	
	9. Birthplace (State or Foreign Country) Caroline Co		10a. State MD		10b. County Prince Georges		10c. City, Town or Location Washington DC	
To Be Completed by Funeral Director	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Black				15. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seamstress		16. Kind of Business/Industry Clothing	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				17. Father's Name (First, Middle, Last) William H Brown		18. Mother's Name (First, Middle, Maiden Surname) Betty Williams	
	19a. Informant's Name/Relationship (Type, Print) Mildred Terry				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15629 Moores Mill Rd Ruther Glen Va 22546			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Rose Lawn Cemetery		20c. Location - City or Town, State 6/20/97 Ashland Va	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Bailey Funeral Home 1207 White St Fredericksburg Va 22401			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MULTI SYSTEM FAILURE Due to (or as a consequence of): b. SEPSIS Due to (or as a consequence of): c. Due to (or as a consequence of): d.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Renal Failure Dementia				24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28. Date of Injury (Month, Day Year) 6/16/97 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 			
	29c. License number 045435				29d. Date signed (Month, Day, Year) 6/16/97			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Suite 301 110 Hospital Rd Prince Frederick MD 20678				31. Date filed (Month, Day, Year) JUN 23 1997			
	32. Registrar's Signature 				33. Registrar's Name J. H. Miller			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1983 JUL 13

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21135

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Arlene M. Twomey

2. Date of Death

Month Day Year
June 16, 1997

3. Time of Death

11:30 p.m.

4a. Facility Name (If not institution, give street and number)

2701 Felter Lane

4b. City, Town, or Location of Death

Bowie

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

005-01-8179

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
May 14, 1913

9. Birthplace (State or Foreign Country)

Maine

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2701 Felter Lane

10f. Zip Code

20715

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Year or Dates: No

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☐ No Specify: No

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Frank Leon McKenney

18. Mother's Name (First, Middle, Maiden Surname)

Edith Jewel

19a. Informant's Name/Relationship (Type, Print)

Raymond E. Twomey

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as # 10.

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Laurel Hills Cemetery 6/20/1997

Date

20c. Location - City or Town, State

Saco, Maine

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Robert E. Evans Funeral Home, Inc.

16000 Annapolis Rd. Bowie, MD 20715

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

End stage COPD

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 years

b.

Congestive heart failure

Due to (or as a consequence of):

2 years

c.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ Raint Fahn M.D.

29c. License number

D43446

29d. Date signed (Month, Day, Year)

6.17.97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROINTAN FARAH FAR M.D. 4000 Mitchellville road B216 Bowie MD 20716

31. Date filed (Month, Day, Year)

JUN 24 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21136

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert E. Thomas				2. Date of Death Month Day Year June 20, 1997		3. Time of Death 11:15 A.M.		
	4e. Facility Name (If not institution, give street and number) 15306 Pine Tree Way				4b. City, Town, or Location of Death Bowie		4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 212 07 4734		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) June 16, 1912		
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Bowie		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 15306 Pine Tree Way		10f. Zip Code 20721		10g. Citizen of What Country? United States	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 43-44		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales		16b. Kind of Business/Industry Automotive					
17. Father's Name (First, Middle, Last) William E. Thomas				18. Mother's Name (First, Middle, Maiden Surname) Virginia E. Geist					
19a. Informant's Name/Relationship (Type, Print) Jerome E. Hoobler Nephew				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 30405 Bethesda Maryland 20804					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State Alexandria Virginia					
21. Signature of Funeral Service Licensee <i>Michael L. B. [Signature]</i>				22. Name and Address of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Md. 20715					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ALZHEIMERS DISEASE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate interval Between Onset and Death 6 yrs					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PNEUMONIA				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. License number D-16897				29d. Date signed (Month, Day, Year) JUNE 20, 1997	
29b. Signature and title of certifier <i>William O. Reason</i>				30. Name and address of person who completed cause of death (Item 23a) (Type and print) William O. Reason MD 5701 85th Ave. New Carrollton Md. 20784					
31. Date filed (Month, Day, Year) JUN 24 1997				32. Registrar's Signature <i>John Andrew [Signature]</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21137

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DOROTHY L. THOMPSON				2. Date of Death Month JUNE Day 13 Year 1997		3. Time of Death 5:00 AM																	
	4a. Facility Name (If not institution, give street and number) 14904 4th Street, # 204				4b. City, Town, or Location of Death Laurel		4c. County of Death Prince Georges																	
Funeral Director	5. Social Security Number 213-18-6160		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) May 19, 1917																	
	9. Birthplace (State or Foreign Country) Maryland		10. Usual Residence of Decedent		11. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		12. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:																	
To Be Completed by Funeral Director	10a. State MD.		10b. County PG		10c. City, Town or Location Laurel		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																	
	10e. Street and Number 14904 4th Street, #204				10f. Zip Code 20707		10g. Citizen of What Country? U.S.A.																	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black																	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housekeeper		16b. Kind of Business/Industry Dept. of Human resources																			
	17. Father's Name (First, Middle, Last) Henry Thompson				18. Mother's Name (First, Middle, Maiden Surname) Addie Brooks																			
	19a. Informant's Name/Relationship (Type, Print) Joan V. Moore - Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14904 4th Street, #204, Laurel, MD 20707																			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MD national Mem. Park		20c. Date 6-18-97		20d. Location - City or Town, State Laurel, MD																	
	21. Signature of Funeral Service Licensee J. P. Marshall				22. Name and Address of Facility Marshall's Funeral Home, Inc. 4217 9th Street N.W. Wash, DC 20011																			
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																							
	<table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>e. COLON CANCER</td> <td>Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death 2yr</td> </tr> <tr> <td rowspan="4">Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. _____</td> <td>Due to (or as a consequence of):</td> <td>_____</td> </tr> <tr> <td>c. _____</td> <td>Due to (or as a consequence of):</td> <td>_____</td> </tr> <tr> <td>d. _____</td> <td>Due to (or as a consequence of):</td> <td>_____</td> </tr> <tr> <td colspan="3"></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	e. COLON CANCER	Due to (or as a consequence of):	Approximate Interval Between Onset and Death 2yr	Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. _____	Due to (or as a consequence of):	_____	c. _____	Due to (or as a consequence of):	_____	d. _____	Due to (or as a consequence of):	_____		
Immediate Cause (Final disease or condition resulting in death)	e. COLON CANCER	Due to (or as a consequence of):	Approximate Interval Between Onset and Death 2yr																					
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. _____	Due to (or as a consequence of):	_____																					
	c. _____	Due to (or as a consequence of):	_____																					
	d. _____	Due to (or as a consequence of):	_____																					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CARCINOMATOSIS						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred																				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier [Signature]		29c. License number D14693		29d. Date signed (Month, Day, Year) 6/18/97																		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) CARLOS VASQUEZ MD 8300 Corporate Drive Landover MD 20785																								
31. Date filed (Month, Day, Year) JUN 25 1997		32. Registrar's Signature [Signature]																						

Items: 23a part 1, 27 per MEO G-749 7/14/97 dh

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Sandra A. Turner				2. Date of Death Month Day Year JUNE 25, 1997		3. Time of Death 0418AM	
	4a. Facility Name (If not institution, give street and number) 2210 BRIGHTSEAT ROAD #301				4b. City, Town, or Location of Death LANDOVER		4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 214-58-2091		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) 44 Yrs.		8. Date of Birth (Month, Day, Year) 03-02-53	
	9. Birthplace (State or Foreign Country) Washington DC		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Landover	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 2210 Brightseat Road #301		10f. Zip Code 20785		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary		16b. Kind of Business/Industry Government			
	17. Father's Name (First, Middle, Last) John W. Turner				18. Mother's Name (First, Middle, Maiden Surname) Burnette Brown			
	19a. Informant's Name/Relationship (Type, Print) Burnette Turner/Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6884 Riverdale Road #443, Lanham, Maryland 20706			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park		Date 7/2/97		20c. Location - City or Town, State Landover, Maryland	
	21. Signature of Funeral Service Licensee Nancy A. Perante				22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Road, Landover, Maryland 20785			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier Nancy A. Perante				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JUNE 25, 1997	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYDAN A. KOSOW 111 Penn Street, Baltimore, Maryland 21201							
	31. Date filed (Month, Day, Year) JUL 01 1997							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

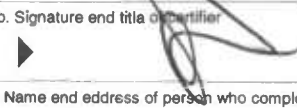
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97 21139

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BERTHA ULBRICHT				2. Date of Death Month JUNE 21 , Day 1997 , Year 2045		3. Time of Death 2045	
	4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital				4b. City, Town, or Location of Death Prince Frederick		4c. County of Death Calvert	
Funeral Director	5. Social Security Number 140-14-7369		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) May 30, 1911	
	9. Birthplace (State or Foreign Country) New Jersey		10a. State Maryland		10b. County Calvert		10c. City, Town or Location Port Republic	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 1415 Walnut Road		10f. Zip Code 20676		10g. Citizen of What Country? U. S. A.	
	11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Maker		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Thomas Wilson				18. Mother's Name (First, Middle, Maiden Surname) Ida Dresbach			
	19a. Informant's Name/Relationship (Type, Print) Marjorie Ryan/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5903 Sixty-First Avenue Riverdale, Maryland 20737			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lee Crematory		20c. Date June 25, 1997		20d. Location - City or Town, State Clinton, Maryland	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8125 So. Md. Blvd. Owings, Maryland 20736					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ASPIRATION PNEUMONIA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
	23b. Approximate Interval Between Onset and Death 3 days							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier 				29c. License number 029657		29d. Date signed (Month, Day, Year) JUNE 22/97	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. CHARLES JUDGE, M.D. PRINCE FREDERICK, MD. 20678							
31. Date filed (Month, Day, Year) JUN 24 1997				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21140

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN THOMAS VICKERS

2. Date of Death

Month
JuneDay
30Year
1997

3. Time of Death

4:15 p.m.

4a. Facility Name (If not institution, give street and number)

Dorchester General Hospital

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

Funeral
Director

5. Social Security Number

214-07-7857

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 24 1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Dorchester

10c. City, Town or Location

Cambridge

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

219 Linthicum Drive

10f. Zip Code

21613

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WW II13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

agent - office manager

16b. Kind of Business/Industry

insurance

17. Father's Name (First, Middle, Last)

John Seward Vickers

18. Mother's Name (First, Middle, Maiden Surname)

Minnie B. James

19a. Informant's Name/Relationship (Type, Print)

Mrs. Grace Vickers-wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

219 Linthicum Drive, Cambridge MD 21613

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Dorchester Memorial Park

Date

7-3-97

20c. Location - City or Town, State

Cambridge Maryland

21. Signature of Funeral Service Licensee

Kenneth R. Thomas Jr.

22. Name and Address of Facility

Thomas Funeral Home PA
700 Locust St. Cambridge MD 2161323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e.

Due to (or as a consequence of):

DIC/disseminated intravascular
coagulopathy.Approximate
Interval Between
Onset and Death

10 hrs

b.

Due to (or as a consequence of):

HTN (malignant)

c.

Due to (or as a consequence of):

Prostate CA

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

severe electrolyte abnormality.

Septicemia.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Ahmed N. Motez

29c. License number

D0050987

29d. Date signed (Month, Day, Year)

6/30/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ahmed N. Motez 105 Aurora Street Cambridge
MD 21613.

31. Date filed (Month, Day, Year)

JUL 2 1997

32. Registrar's Signature

John Seward Vickers

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph A. Ward

2. Date of Death
Month Day Year

6 26 1997

3. Time of Death

8:50pm

4a. Facility Name (If not institution, give street and number)

University of Maryland Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

212-56-0951

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

47 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

03-15-1950

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Somerset

10c. City, Town or Location

Princess Anne

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

36791 Antioch Ave

10f. Zip Code

21853

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

10th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Self Employed

16b. Kind of Business/Industry

Private Contractor

17. Father's Name (First, Middle, Last)

William T. Ward Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Kannie L. Cottman

19a. Informant's Name/Relationship (Type, Print)

Elizabeth McClinton / sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12379 Fenlon Circle Princess Anne MD 21853

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Samuel Wesley Cem

Date

7-1-97

20c. Location - City or Town, State

Marokin MD

21. Signature of Funeral Service Licensee

Anthony E. Ward

22. Name and Address of Facility

Anthony E. Ward Funeral Home
30639 Hampden Ave Princess Anne, MD 21853

23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Chronic Heart Failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 days

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Valvular disease

Due to (or as a consequence of):

2 months

c. Acute Myocardial Infarction

Due to (or as a consequence of):

1 day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Debra M. Bensen MD

29c. License number

29d. Date signed (Month, Day, Year)

6/26/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DEBRA M. BENSON M.D. 22 SOUTH GREEN ST, BALTIMORE MD 21201

31. Date filed (Month, Day, Year)

JUL - 1 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

97 21142

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Delmarr L. Woerner				2. DATE OF DEATH MONTH DAY YEAR June 22, 1997		3. TIME OF DEATH 1745 M	
4. SOCIAL SECURITY NUMBER 304-28-3693		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan 24 1929	
9a. FACILITY NAME (If not institution, give street and number) Laurelwood Nursing & Rehab Center		9b. CITY, TOWN OR LOCATION OF DEATH Elkton				9c. COUNTY OF DEATH Cecil	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION Rising Sun		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 23 Berkley Rd.				10f. ZIP CODE 21911		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Navy 1948-1968		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Maintenance		16b. KIND OF BUSINESS/INDUSTRY Medical			
17. FATHER'S NAME (First, Middle, Last) Lewis Merle Woerner				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ruth Frances Stevens			
19a. INFORMANT'S NAME (Type/Print) Dolores A. Woerner, Daughter				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23 Berkley Rd. Rising Sun MD 21911			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Ebenezer Cemetery June 26 1997		20c. LOCATION — City or Town, State Rising Sun MD		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Richard L. Goodie</i>				22. NAME AND ADDRESS OF FACILITY R. T. Foard Funeral Home, PA 111 S Queen St. Rising Sun MD 21911			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Methicillin Resistant Staphylococcus Endocarditis DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death 3 weeks	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. ST. Jude Mechanical Aortic Valve DUE TO (OR AS A CONSEQUENCE OF):				3 years	
		c. Aortic Valve Insufficiency DUE TO (OR AS A CONSEQUENCE OF):				3 years	
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery Disease; Diabetes Mellitus Type I End-stage Renal Disease							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Monte Makous, MD					
29c. LICENSE NUMBER D-44783		29d. DATE SIGNED (Month, Day, Year) June 23, 1997					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MONTE MAKOUS, MD 111 WEST HIGH STREET, ELKTON, MD 21921							
31. DATE FILED (Month, Day, Year) JUN 26 1997		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendell</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21143

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Loretta Combs Wise

2. Date of Death

June 16 1997

3. Time of Death

7:00 PM.

4a. Facility Name (If not institution, give street and number)

St. Mary's Hospital

4b. City, Town, or Location of Death

Leonardtown

4c. County of Death

St. Mary's

5. Social Security Number

577-26-4094

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

February 9, 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

St. Mary's City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

General Delivery

10f. Zip Code

20686

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Postal Clerk

16b. Kind of Business/Industry

U.S. Postal Service

17. Father's Name (First, Middle, Last)

William Parran Combs

18. Mother's Name (First, Middle, Maiden Surname)

Blanche Victoria Redmond

19a. Informant's Name/Relationship (Type, Print)

John Albert Wise, Sr., Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

General Delivery, St. Mary's City, Maryland 20686

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Trinity Church Cemetery

Date

6-20-97

20c. Location - City or Town, State

St. Mary's City, Maryland

21. Signature of Funeral Service Director

Edward N. Brinsfield, Jr., MD052

22. Name and Address of Facility

Brinsfield Funeral Home, P.A.
22955 Hollywood Road, Leonardtown, Maryland 20650-0279

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

a. *Cardiopulmonary Failure*
Due to (or as a consequence of):

b. *Vasculitis, generalized*
Due to (or as a consequence of):

c. *Systemic Lupus Erythematosus*
Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

1 day

1 mo

15 yrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 06419

29d. Date signed (Month, Day, Year)

6-17-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JAMES P. JARBOE M.D.

LEONARDTOWN, MD. 20650

31. Date filed (Month, Day, Year)

JUN 18 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

LORETTA COMBS WISE

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21144

AMENDED #16a BLT, 6-25-97 ST. MARY'S CO.

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Francis Aloysius Watermolen					2. Date of Death Month Day Year June 12 1997		3. Time of Death 3:45 PM		
	4a. Facility Name (If not institution, give street and number) 24700 McIntosh Rd.					4b. City, Town, or Location of Death Hollywood		4c. County of Death St. Mary		
Funeral Director	5. Social Security Number 399-07-2053		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) August 16, 1920 WI		9. Birthplace (State or Foreign Country)	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County St. Mary		10c. City, Town or Location Hollywood		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number 24700 McIntosh Rd.				10f. Zip Code 20636		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use rating.) AVIATION MECHANIST Military Admiral		16b. Kind of Business/Industry U.S. Government					
	17. Father's Name (First, Middle, Last) J Watermolen					18. Mother's Name (First, Middle, Maiden Surname) F. Panure				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Maraget Watermolen/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24700 McIntosh Rd., Hollywood, MD 20636					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Charles Memorial Gardens		20c. Location - City or Town, State Leonardtown, MD		20d. Date 6/16/97			
	21. Signature of Funeral Service Licensee <i>Michael R. Gardiner</i>				22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Carcinomatous Cancer of Prostate</i> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Approximate Interval Between Onset and Death <i>months</i> <i>yes</i>									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	24b. Were autopsy findings available prior to completion of cause of death? <i>N.A.</i>					24c. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>James P. Jarboe MD</i>		29c. License number D 06419		29d. Date signed (Month, Day, Year) 6-17-97			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Patrick Jarboe, M.D. Leonardtown, MD 20650										
State Registrar	31. Date filed (Month, Day, Year) JUN 18 1997				32. Registrar's Signature <i>John Davidson-Randall</i>					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21145

Certificate of Death

Reg. No.

Amended Item #18 WCHD 7/1/97 ET

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CATHERINE VIRGINIA NEWTON WILLIAMS

2. Date of Death

June 30, 1997

3. Time of Death

1325 PM

4a. Facility Name (If not institution, give street and number)

ATLANTIC GENERAL HOSPITAL

4b. City, Town, or Location of Death

BERLIN

4c. County of Death

WORCESTER

Funeral
Director

5. Social Security Number

577 26 0690

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

NOV. 21, 1921

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Worcester

10c. City, Town or Location

Ocean City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9001 E. Biscayne Dr.

10f. Zip Code

21842

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Beautician

16b. Kind of Business/Industry

Hairdressing Industry

17. Father's Name (First, Middle, Last)

Henry C. Newton

18. Mother's Name (First, Middle, Maiden Surname)

Mae Elizabeth (Unknown) Abernathy

19a. Informant's Name/Relationship (Type, Print)

Thomas A. Moody

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3309 Elk Creek Rd. Mineral, VA 23117

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cape Henlopen Crematory

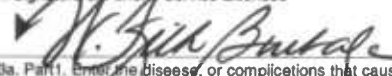
Date

7/1/97

20c. Location - City or Town, State

Frankford, DE

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Burbage Funeral Home

108 William Street

Berlin, MD

21811

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Carcinoma of Lung

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Pneumonia.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

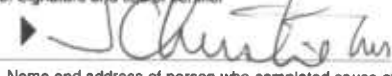
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D0050605.

29d. Date signed (Month, Day, Year)

June 30 97.

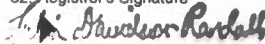
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. CHRISTIE MD
9733 Healthway Dr, Berlin Md 21811

31. Date filed (Month, Day, Year)

JUL 01 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

21146

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Paul A. Williams, Sr.

2. Date of Death

June 24, 1997

3. Time of Death

1342

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

218-14-4432

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

10-3-1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State
Maryland10b. County
Worcester10c. City, Town or Location
Pocomoke City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1903 Broad Street

10f. Zip Code

21851

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Painter

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

John A. Williams

18. Mother's Name (First, Middle, Maiden Surname)

Emma Gibbons

19a. Informant's Name/Relationship (Type, Print)

Virginia Williams / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1903 Broad St., Pocomoke, Md. 21851

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

First Baptist Cemetery 6-27-97 Pocomoke, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Scott S. Melson

22. Name and Address of Facility

Melson Funeral Home
P.O. Box 64, Pocomoke, Md. 2185123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

cardiac arrhythmia

Due to (or as a consequence of):

b.

cardiomyopathy

Due to (or as a consequence of):

c.

coronary artery disease

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

immediate

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Charles B. Silva, Jr.

29c. License number

D30853

29d. Date signed (Month, Day, Year)

6/24/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10 Charles B. Silva, Jr. PRMC - Salisbury, Md.

State
Registrar

31. Date filed (Month, Day, Year)

JUN 27 1997

32. Registrar's Signature

John Davidson-Randall

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Paul Williams

Baltimore, Maryland 21215-0020

6/11/19

Dear Sir,
I have the pleasure to acknowledge the receipt of your letter of the 10th inst. in relation to the above matter.

I am sorry to hear that you are having trouble with the machine. I will try to get a replacement for you as soon as possible.

I am sure that you will find the new machine to be of great value to your business. I will be sure to get it to you as soon as it is available.

I am sure that you will find the new machine to be of great value to your business. I will be sure to get it to you as soon as it is available.

I am sure that you will find the new machine to be of great value to your business. I will be sure to get it to you as soon as it is available.

I am sure that you will find the new machine to be of great value to your business. I will be sure to get it to you as soon as it is available.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21147

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Newton Weaver, Sr.

2. Date of Death

Month Day Year
June 26 1997

3. Time of Death

2:40AM

4a. Facility Name (If not institution, give street and number)

Atlantic General Hospital

4b. City, Town, or Location of Death

Berlin

4c. County of Death

Worcester

Funeral
Director

5. Social Security Number

213-03-2270

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 8, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Worcester

10c. City, Town or Location

Ocean City

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2 S. Baltimore Ave.

10f. Zip Code

21842

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Master Machinist

16b. Kind of Business/Industry

Matrix Service Co.

17. Father's Name (First, Middle, Last)

James Robert Weaver

18. Mother's Name (First, Middle, Maiden Surname)

Regina Abendschoen

19a. Informant's Name/Relationship (Type, Print)

Charles Newton Weaver, Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2 S. Baltimore Ave., Ocean City, Md. 21842

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cape Henlopen Crematory 6-26-97 Frankford, Delaware

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

The Burbage Funeral Home
108 William St., Berlin, Md. 21811

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction
Due to (or as a consequence of):

days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary artery
Due to (or as a consequence of):
c. renal FAILURE
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D47676

29d. Date signed (Month, Day, Year)

6/26/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bsher A. Touleimat, MD 9733 Healthway Dr. Berlin, MD 21811

31. Date filed (Month, Day, Year)

JUN 27 1997

32. Registrar's Signature

John Anderson-Rodell

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

21148

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ALFRED EUGENE WASHINGTON

2. Date of Death

Month

Day

Year

JUNE 24

1997

5:50 AM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

PRINCE GEORGES HOSPITAL CENTER

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

577-58-9913

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

51

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Dec. 16, 1945

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Seat Pleasant

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6233 Addison Road

10f. Zip Code

20743

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

African American

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Mailroom Technician

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Robert L. Washington

18. Mother's Name (First, Middle, Maiden Surname)

Thelma E. Brown

19a. Informant's Name/Relationship (Type, Print)

Thelma B. Washington - Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6233 Addison Road, Seat Pleasant, Maryland 20743

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Ft. Lincoln Cemetery

Date

6/27/97

20c. Location - City or Town, State

Brentwood, MD

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

STEWART FUNERAL HOME, Inc.

4001 Benning Road, N. E., Washington, D.C.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e. Septicemia

Due to (or as a consequence of):

Jaw

~ week

Sequentially list conditions,
if any, leading to immediate
cause. Enter underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Ischemic hepatitis

Due to (or as a consequence of):

Jaw

~ week

c. End stage renal failure

Due to (or as a consequence of):

Jaw

~ months

d. Pulmonary edema 2° to volume overload ~ months

e. Sarcoidosis - multi-organ involvement ~ years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

No Seizure disorder

pancreatitis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John Dixon Webber, MD

29c. License number

D46518

29d. Date signed (Month, Day, Year)

6/24/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Jan D. Webber, MD PGHC 3001 Hospital Dr. Cheverly, M.D.

31. Date filed (Month, Day, Year)

JUN 27 1997

32. Registrar's Signature

John Stewart-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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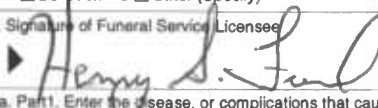

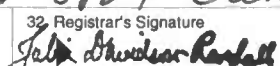
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

21149

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Anne Elizabeth Wade					2. Date of Death Month June Day 25 Year 1997		3. Time of Death 10:45 PM				
	4e. Facility Name (If not Institution, give street end number) Doctors Community Hospital					4b. City, Town, or Location of Death Lanham		4c. County of Death Prince George's				
Funeral Director	5. Social Security Number 223-12-8504		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 13, 1920		9. Birthplace (State or Foreign Country) Virginia			
	Usual Residence of Decedent											
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location College Park				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
10e. Street and Number 4711 Berwyn House Road #311					10f. Zip Code 20740		10g. Citizen of What Country? U.S.A.					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) College					16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home				
17. Father's Name (First, Middle, Last) Artie Royal Brooks					18. Mother's Name (First, Middle, Maiden Surname) Nannie Fletcher Steppe							
19a. Informant's Name/Relationship (Type, Print) Brenda A. Manis - Daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9612 Van Buren Street, Seabrook, Maryland 20706							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		Date 6/28/97		20c. Location - City or Town, State Brentwood, Maryland					
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
<table border="0" style="width:100%;"> <tr> <td style="width:30%; vertical-align: top;"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td style="width:50%; vertical-align: top;"> a. cardiac arrest Due to (or as a consequence of): b. urosepsis Due to (or as a consequence of): c. complete stroke Due to (or as a consequence of): d. carotid artery stenosis </td> <td style="width:20%; vertical-align: top;"> Approximate Interval Between Onset and Death acute 10 days 2 months 2 months </td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. cardiac arrest Due to (or as a consequence of): b. urosepsis Due to (or as a consequence of): c. complete stroke Due to (or as a consequence of): d. carotid artery stenosis	Approximate Interval Between Onset and Death acute 10 days 2 months 2 months
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. cardiac arrest Due to (or as a consequence of): b. urosepsis Due to (or as a consequence of): c. complete stroke Due to (or as a consequence of): d. carotid artery stenosis	Approximate Interval Between Onset and Death acute 10 days 2 months 2 months										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
							24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
29b. Signature and title of certifier 					29c. License number D13339		29d. Date signed (Month, Day, Year) 6/26/97					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) T. CHANCETEN 8824 Cunningham Drive, Berwyn Heights MD												
31. Date filed (Month, Day, Year) JUN 27 1997					32. Registrar's Signature 							

To Be Completed by Funeral Director

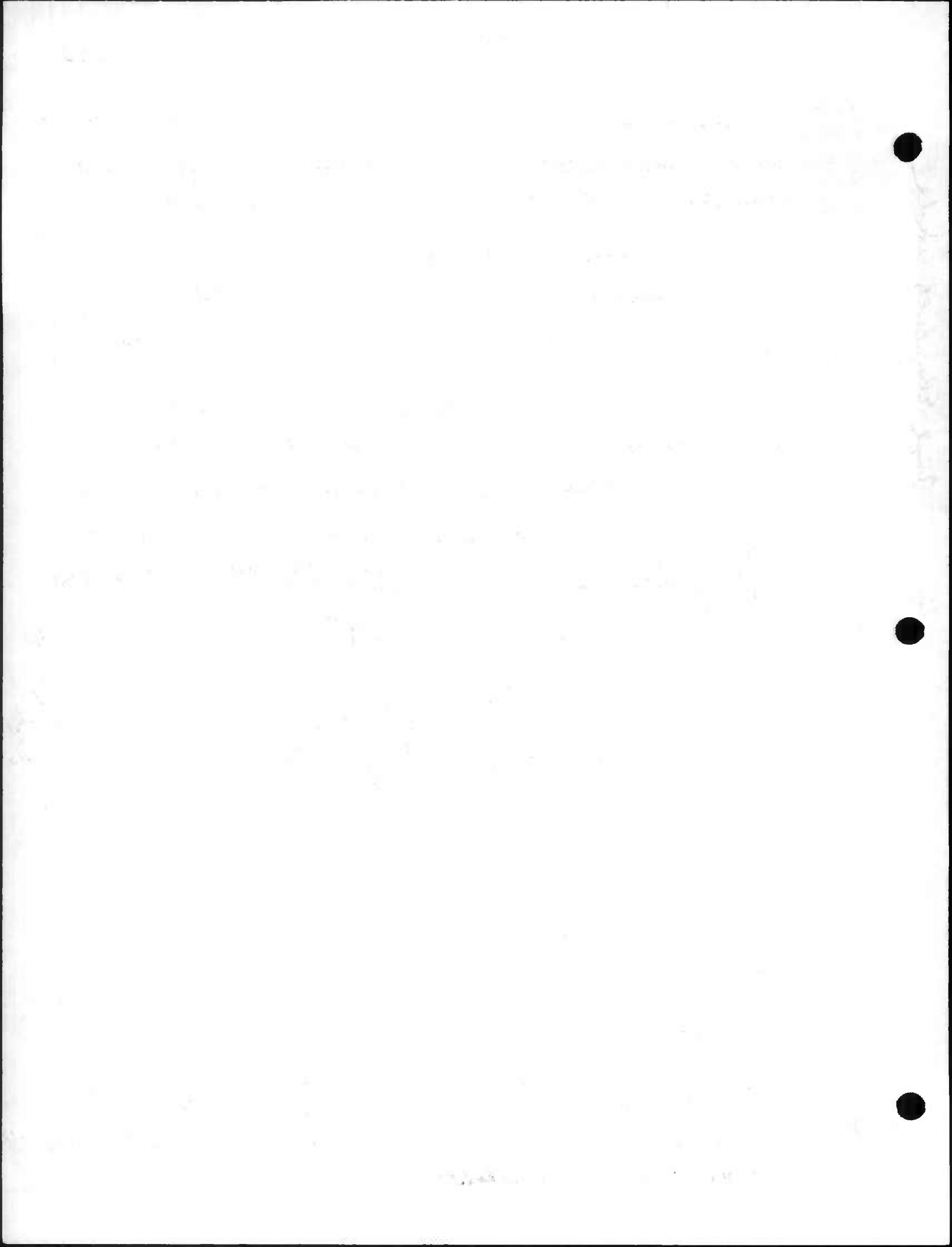
Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21150

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charlie O. Williams

2. Date of Death

Month
JuneDay
19Year
1997

3. Time of Death

11:04 AM

4a. Facility Name (If not institution, give street and number)

Doctors Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince Georges

Funeral
Director

5. Social Security Number

245-01-9792

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

09-08-07

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Riverdale

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

6801 Emerson Street

10f. Zip Code

20737

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8th

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Printer

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Jack Dallas Williams

18. Mother's Name (First, Middle, Maiden Surname)

Geneva Jones

19e. Informant's Name/Relationship (Type, Print)

Venetta Thomas/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6801 Emerson Street, Riverdale, MD 20737

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Park

Date

06/23
1997

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

Nancy A. Perentis

22. Name and Address of Facility

J.B. Jenkins Funeral Home

7474 Landover Road, Landover, MD 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Coronary Artery Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☒ ER/Outpatient ☐ DOAOther: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier

[Signature]

29c. License number

D20989

29d. Date signed (Month, Day, Year)

June 20, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Elwood Holland, MD 6005 Landover Road, Suite 3, Cheverly, MD 20785

31. Date filed (Month, Day, Year)

JUN 24 1997

32. Registrar's Signature

[Signature]

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

CHARLIE WILLIAMS
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21151

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Bobbie

2. Date of Death

Month

Day

Year

JUNE

18

1997

3. Time of Death

2052

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

5. Social Security Number

578-54-4532

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

58 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 7, 1939

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Forestville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2618 Timbercrest Drive

10f. Zip Code

20747

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

11th

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Telephone Operator

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Othel Wilkins

18. Mother's Name (First, Middle, Maiden Surname)

Helen Foster

19a. Informant's Name/Relationship (Type, Print)

Thomas E. Wood/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2618 Timbercrest Drive, Forestville, Maryland 20747

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Harmony Memorial Park

Date

06/24
1997

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

Nancy A. Perentis

22. Name and Address of Facility

J. B. JENKINS FUNERAL HOME

7474 Landover Road, Landover, Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)e. Hypoxia
Due to (or as a consequence of):b. Pneumonia
Due to (or as a consequence of):c. Immunosuppression
Due to (or as a consequence of):d. Pulmonary Sarcoidosis
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

days

weeks

years

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ventricular septal defect

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Joel Blankson Medicine Resident

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

June 19 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Joel Blankson MD 110 Tower Building 600 North Wolfe Street Baltimore MD 21287

31. Date filed (Month, Day, Year)

JUN 24 1997

32. Registrar's Signature

Julie Anderson-Robert

State
Registrar

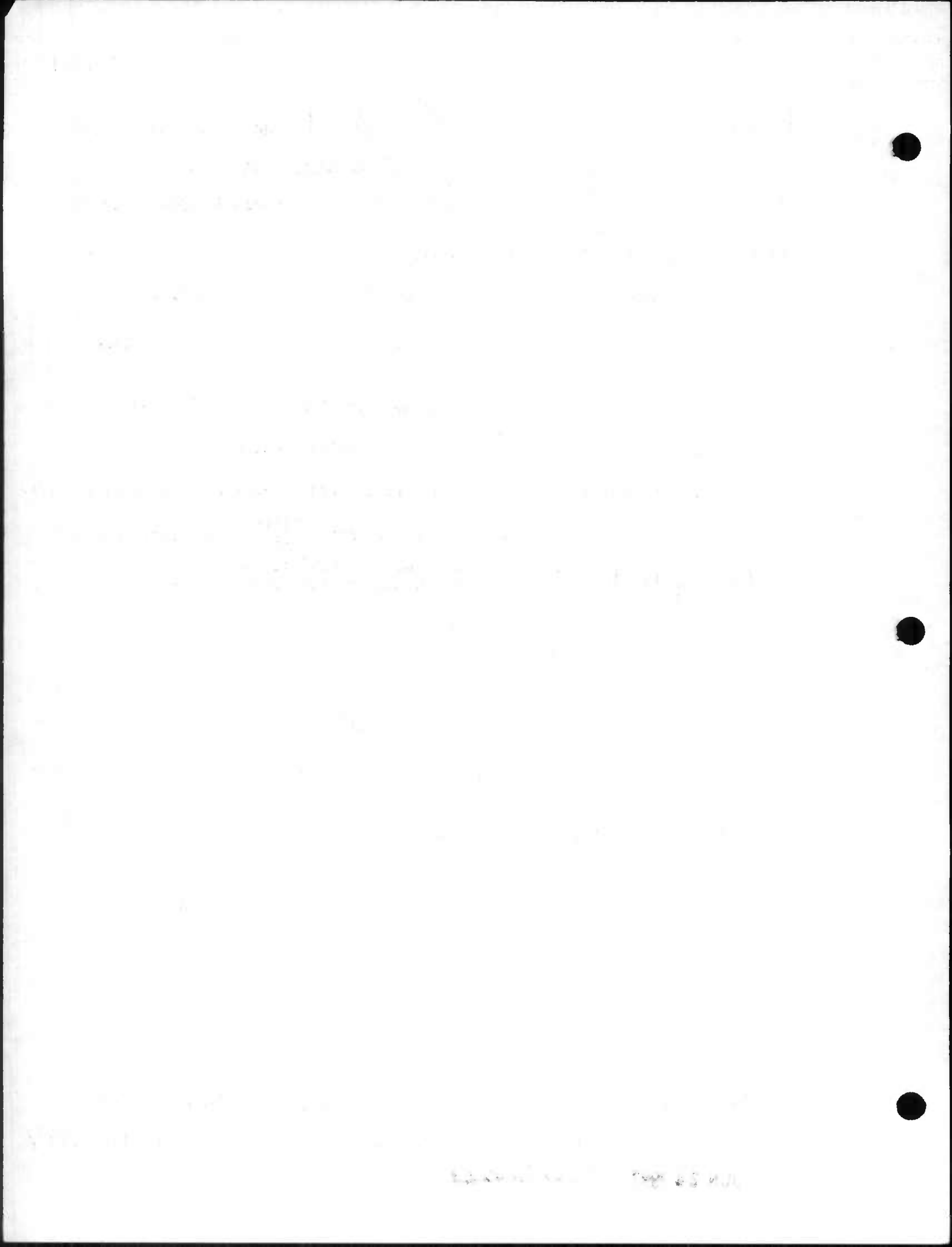
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21152

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SYLVANIA W. WOODS, SR.				2. Date of Death Month Day Year June 21 1997		3. Time of Death 8:55AM				
	4a. Facility Name (If not institution, give street and number) Doctors Community Hospital				4b. City, Town, or Location of Death Lanham		4c. County of Death Prince Georges				
Funeral Director	5. Social Security Number 257-20-2712		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) 08-04-27		9. Birthplace (State or Foreign Country) Georgia		
	Usual Residence of Decedent										
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Glenarden				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 7816 Fiske Avenue				10f. Zip Code 20706		10g. Citizen of What Country? USA					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: to 4/2/43 to 12/13/45		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Judge		16b. Kind of Business/Industry Government					
17. Father's Name (First, Middle, Last) Andrew Woods				18. Mother's Name (First, Middle, Maiden Surname) Cora Mathis							
19a. Informant's Name/Relationship (Type, Print) Geneva Woods/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7816 Fiske Avenue, Glenarden, Maryland 20706							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Ceme.		Date 06/27 1997		20c. Location - City or Town, State Cheltenham, Maryland					
21. Signature of Funeral Service Licensee Nancy A. Perentis				22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Road, Landover, Maryland 20785							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last a. Fungal Sepsis. Due to (or as a consequence of): b. Severe biventricular heart failure Due to (or as a consequence of): c. Chronic renal failure Due to (or as a consequence of): d. Diabetes mellitus, insulin dependent										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier M. Hernandez		29c. License number D08520		29d. Date signed (Month, Day, Year) 6/21/97			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 7525 Greenway Center Suite T-6 Greenbelt MD Dr. Tomas Hernandez											
31. Date filed (Month, Day, Year) JUN 24 1997				32. Registrar's Signature John Anderson							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

20

State
Registrar

97-3552-031

B.K.S

PHILLIP YUNGER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21153

Items: 23a part I, 27, 28a-f per ME0 G-749 7/14/97 dh

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PHILIP W. YUNGER				2. Date of Death Month JUNE Day 27 Year 1997		3. Time of Death 0654AM		
	4a. Facility Name (If not institution, give street and number) 10008 REDDICK ROAD				4b. City, Town, or Location of Death SILVER SPRING		4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 003 64 1502		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 24 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) OCT 1, 1973	9. Birthplace (State or Foreign Country) WASHINGTON, D.C.	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State D.C.		10b. County NONE		10c. City, Town or Location WASHINGTON, D.C.		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 1406 NEWTON STREET N.E.				10f. Zip Code 20017		10g. Citizen of What Country? USA		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 yr.		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) STAGE HAND		16b. Kind of Business/Industry THEATER				
	17. Father's Name (First, Middle, Last) PHILIP G. YUNGER				18. Mother's Name (First, Middle, Maiden Surname) BARBARA JONES				
	19a. Informant's Name/Relationship (Type, Print) PHILIP G. YUNGER (FATHER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1406 NEWTON ST. N.E.				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) RIVERDALE CREMATORY		Date JUN 28, 1997		20c. Location - City or Town, State RIVERDALE, MD		
	21. Signature of Funeral Service Licensee <i>Ralph Williams</i>				22. Name and Address of Facility RALPH WILLIAMS FUNERAL SVC 517 11th STREET S.E.				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. NARCOTIC AND METHAMPHETAMINE INTOXICATION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) found: 6/27/97		28b. Time of Injury unknown M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred unknown	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) home				28f. Location (Street and Number or Rural Route Number, City or Town, State) 10008 Reddick, Silver Spring, Md.			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Stephen S. Radentz, MD</i>		29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) JUNE 27, 1997			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Stephen S. Radentz, MD 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) JUL 07 1997		32. Registrar's Signature <i>Julia Ann... Radentz</i>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Amended item #10b per F.D.
6/30/97 Carroll Co. p.l.c.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) AVIS ELIZABETH ZEPP				2. Date of Death Month JUNE Day 25 Year 1997		3. Time of Death 11:10 AM			
4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore			
5. Social Security Number 212-05-1027		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 21, 1918 PA			
9. Birthplace (State or Foreign Country) PA									
Usual Residence of Decedent									
10a. State MD		10b. County Baltimore Carroll		10c. City, Town or Location Upperco		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 5712 Emory Road				10f. Zip Code 21155		10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher		16b. Kind of Business/Industry Elementary Education			
17. Father's Name (First, Middle, Last) Charles Arthur Butts				18. Mother's Name (First, Middle, Maiden Surname) Elsie Markle					
19a. Informant's Name/Relationship (Type, Print) Mr. William Zepp (son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5710 Emory Road Upperco, MD 21155					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Evergreen Memorial Gardens 6/27		20c. Location - City or Town, State Finksburg, MD					
21. Signature of Funeral Service Licensee Brian L. Haight				22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL (Box 195) Sykesville, MD 21784 (410)-795-1400					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ACUTE MYOCARDIAL INFARCTION								Approximate Interval Between Onset and Death 48 HOURS	
Immediata Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No			
		28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Beatriz P. Dizon, M.D.							
		29c. License number D 16492		29d. Date signed (Month, Day, Year) June 25, 1997					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BEATRIZ P. DIZON, M.D., 7620 YORK ROAD, TOWSON, MD. 21204									
31. Date filed (Month, Day, Year) JUN 26 1997				32. Registrar's Signature Julia Shuler Carroll					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Item 1 8-4-97 Film 750 W.H.Per Doctor

97 21155

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>David E. I. Armstrong</i>				2. Date of Death Month <i>7</i> Day <i>10</i> Year <i>97</i>		3. Time of Death <i>440am</i>								
	4a. Facility Name (If not institution, give street and number) <i>Johns Hopkins Bayview Medical Center</i>				4b. City, Town, or Location of Death <i>Baltimore, MD</i>		4c. County of Death <i>city</i>								
Funeral Director	5. Social Security Number <i>215-66-4908</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>39</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>OCT. 17 1957</i>								
	9. Birthplace (State or Foreign Country) <i>MARYLAND</i>		10a. State <i>MARYLAND</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>BALTIMORE CITY</i>								
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <i>4836 BOWLAND AVENUE</i>		10f. Zip Code <i>21206</i>		10g. Citizen of What Country? <i>U.S.A.</i>								
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>BLACK</i>								
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12yrs</i>		College (1-4 or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>WELDER</i>		16b. Kind of Business/Industry <i>BETHELHEM STEELE</i>								
	17. Father's Name (First, Middle, Last) <i>JOSEPH ARMSTRONG, JR.</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>MELBA PRESTON</i>										
	19a. Informant's Name/Relationship (Type, Print) <i>Melba P. Armstrong/Mother</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>6401 Loch Raven Blvd, Apt 301, Baltimore, Maryland 21239</i>										
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>HOLLY HILLS MEM. GARDENS</i>		Date <i>07-15</i>		20c. Location - City or Town, State <i>MIDDLE RIVER, MARYLAND</i>								
	21. Signature of Funeral Director <i>[Signature]</i>				22. Name and Address of Facility <i>WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE</i>										
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.														
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <i>Liver failure</i></td> <td rowspan="4">Due to (or as a consequence of):</td> <td rowspan="4">Approximate interval between Onset and Death <i>1 yr</i></td> </tr> <tr> <td>b. <i>cirrhosis</i></td> </tr> <tr> <td>c.</td> </tr> <tr> <td>d.</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. <i>Liver failure</i>	Due to (or as a consequence of):	Approximate interval between Onset and Death <i>1 yr</i>	b. <i>cirrhosis</i>	c.	d.
	Immediate Cause (Final disease or condition resulting in death)	a. <i>Liver failure</i>	Due to (or as a consequence of):	Approximate interval between Onset and Death <i>1 yr</i>											
b. <i>cirrhosis</i>															
c.															
d.															
<table border="1"> <tr> <td colspan="4">23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown</td> </tr> <tr> <td colspan="2">24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> <td colspan="2">24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> </tr> </table>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown															
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <i>76117</i>		29d. Date signed (Month, Day, Year) <i>7/10/97</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>John TenBroek MD 4940 Eastern Ave. Baltimore MD 21224</i>							
31. Date filed (Month, Day, Year) <i>JUL 14 1997</i>				32. Registrar's Signature <i>[Signature]</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21156

Item5 8-22-97 FilmG750 W.H.Per F/H

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY ALLEN

2. Date of Death

Month Day Year
JULY 7, 1997

3. Time of Death

11:15 P.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

LIBERTY MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

194-26-1200

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

64

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

DEC. 29, 1932

9. Birthplace (State or Foreign Country)

PENNSYLVANIA

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2835 PRESBURY STREET

10f. Zip Code

21216

10g. Citizen of What Country?

U.S. OF A.

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
BLACK15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10 TH

College (1-4 or 5+)

N/A

16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

SEAMSTRESS

16b. Kind of Business/Industry

SEWING FACTORY

17. Father's Name (First, Middle, Last)

WALTER BURRELL

18. Mother's Name (First, Middle, Maiden Surname)

DOLLY HULL

19a. Informant's Name/Relationship (Type, Print)

DARNETTA SHAVERS (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3723 BELLE AVE. BALTO., MD. 21215

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

GARRISON FOREST VET. CEM.

20c. Location - City or Town, State

BALTO.
OWINGS MILLS, MD. CO.

21. Signature of Funeral Service Licensee

Lewis T. Gwynn

22. Name and Address of Facility

LEWIS T. GWYNN FUNERAL HOME 21215-6393
4517 PARK HEIGHTS AVE. BALTO., MD.23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

b. Morbid Obesity

Due to (or as a consequence of):

c. Cardiac Arrhythmias

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☒ Yes ☐ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

George E. Wicks III M.D.

29c. License number

D41365

29d. Date signed (Month, Day, Year)

July 7, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

George E. Wicks III M.D.

2600 Liberty Heights Ave. 21215

31. Date filed (Month, Day, Year)

JUL 14 1997

32. Registrar's Signature

John R. Anderson

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0028
permit. Pages 1 and 2 should be filled within 24 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

100

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100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21157

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Anna Asten

2. Date of Death

Month Day Year
July 10 1997

3. Time of Death

11:28am

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Geriatrics Ctr.

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

216-16-5588

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

if Under 1 Year

Months Days

if Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 6, 1914

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

511 South 47th Street

10f. Zip Code

21224

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8 Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Machine Operator

16b. Kind of Business/Industry

Manufacturing

17. Father's Name (First, Middle, Last)

William Baisley

18. Mother's Name (First, Middle, Maiden Surname)

Ethel Harris

19a. Informant's Name/Relationship (Type, Print)

Katherine L. Asten/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

511 South 47th Street Baltimore, Maryland 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Oak Lawn Cemetery 7/12/1997

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

John J. Giddens

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 2122223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. pneumonia

Due to (or as a consequence of):

b. COPD

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 week

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Stroke

CHF

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and Title of certifier

John J. Giddens MD

29c. License number

D0052243

29d. Date signed (Month, Day, Year)

07/11/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Jacob Blumenthal 5505 Hopkins Bayview Circle 21224

State
Registrar

31. Date filed (Month, Day, Year)

JUL 14 1997

Registrar's Signature

John J. Giddens

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 must be completed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene. Important: If item 27 is checked, other than "natural", or items 23a or 23e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

and they are the same as the ones in the first part of the book. The only difference is that the second part of the book is more detailed and more complete. The first part of the book is more general and more introductory. The second part of the book is more specific and more detailed. The first part of the book is more general and more introductory. The second part of the book is more specific and more detailed.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21158

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CYNTHIA ANDERSON				2. Date of Death Month JULY Day 3 Year 1997		3. Time of Death 10:30 AM		
	4a. Facility Name (If not institution, give street and number) MARYLAND GENERAL HOSPITAL				4b. City, Town, or Location of Death BALTO.		4c. County of Death N/A		
Funeral Director	5. Social Security Number 218-60-3999		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 48 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 4-15-1949	9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent								
10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 929 FRANKLINTOWN RD				10f. Zip Code		10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: AFR. AMERICAN			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NURSE'S ASST.		16b. Kind of Business/Industry HOSPITAL			
17. Father's Name (First, Middle, Last) JAMES DOLES				18. Mother's Name (First, Middle, Maiden Surname) MARIAM YARBROUGH					
19a. Informant's Name/Relationship (Type, Print) LYDIA HAWKINS (DAUGHTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4313 DANA STREET BALTO. MD 21229					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) KINGS MEM. PARK		Date 7/7/1997		20c. Location - City or Town, State RANDALLSTOWN MD			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTO. MD 21217					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MULTIPLE MYELOMA WITH METASTASIS Due to (or as a consequence of): b. CHRONIC RENAL FAILURE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier TEHMINA KANWAL, M.D.				29c. License number 89265		29d. Date signed (Month, Day, Year) 7/7/97			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TEHMINA KANWAL, M.D. c/o MARYLAND GENERAL HOSPITAL									
31. Date filed (Month, Day, Year) JUL 14 1997				32. Registrar's Signature 					

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 9008.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

7

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item 26, 24a 7-14-97 Film G749 W.H. Perr Doctor

State of Maryland / Department of Health and Mental Hygiene

97 21159

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Armondo L. Alessandri				2. Date of Death June 29 1997		3. Time of Death 9:05 AM	
	4e. Facility Name (If not institution, give street and number) Fallston General Hospital				4b. City, Town, or Location of Death Fallston		4c. County of Death Harford	
Funeral Director	5. Social Security Number 209-16-2520		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 30, 1926	9. Birthplace (State or Foreign Country) Pennsylvania
	Usual Residence of Decedent				10c. City, Town or Location Bel Air		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. State Maryland		10b. County Harford		10f. Zip Code 21014		10g. Citizen of What Country? U.S.A.	
	10e. Street end Number 955 L. Hillswood Road		10f. Zip Code 21014		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th grade College (1-4 or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Claims Examiner		16b. Kind of Business/Industry Social Security Adm.			
	17. Father's Name (First, Middle, Last) Lorenzo Alessandri				18. Mother's Name (First, Middle, Maiden Surname) Teresa Cruciani			
	19a. Informant's Name/Relationship (Type, Print) Anna Mae Alessandri (wife)				19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 955 L. Hillswood Rd., Bel Air, MD 21014			
	20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery		Date 7/2/97		20c. Location - City or Town, State Baltimore, Maryland	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Rd., Bel Air, MD 21014			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	<p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. Cardiac Arrest Due to (or as a consequence of):</p> <p>b. Coronary artery disease (3 vessel) Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> <p>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cardiomyopathy Carcinoma of the stomach						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28e. Date of Injury (Month, Day, Year) June 29 1997		28b. Time of Injury M		28c. Injury at Work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
28a. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Location (Street end Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier D. L. Provodsky MD				29c. License number DO 9574		29d. Date signed (Month, Day, Year) 6/30/97		
30. Name and address of person who completed cause of death (item 23e) (Type, Print) 104 Plumtree Rd Bel Air, Md. 21014								
31. Date filed (Month, Day, Year) JUL 09 1997				32. Registrar's Signature Julia Davidson-Randall				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

CURTIS D. BAILEY, SR.

State of Maryland / Department of Health and Mental Hygiene

97 21160

Item: 23a part 1, per MEO G-750 8/11/97 dh
Items: 23a part 1, 27 per MEO G-749 7/18/97 dh

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CURTIS D. BAILEY SR.				2. Date of Death Month Day Year JULY 09, 1997		3. Time of Death 0623AM	
	4a. Facility Name (If not institution, give street and number) 7230 CLARKDAVIS COURT				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death N/A	
Funeral Director	5. Social Security Number 214-76-1888		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 39 Yrs.		8. Date of Birth (Month, Day, Year) 8-23-57	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State Md.		10b. County N/A		10c. City, Town or Location BALTIMORE	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 7230 CLARKDAVIS COURT		10f. Zip Code 21237		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABOR		16b. Kind of Business/Industry CONSTRUCTION			
	17. Father's Name (First, Middle, Last) WINDFIELD BAILEY		18. Mother's Name (First, Middle, Maiden Surname) CLARICE JACKSON		19a. Informant's Name/Relationship (Type, Print) CLARICE JACKSON-MOTHER			
Physician /Medical Examiner	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7230 CLARKDAVIS CT. BALTO. MD 21237		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT ZION CEMETERY 7/14/97		20c. Location - City or Town, State BALTO. MD.	
	21. Signature of Funeral Service Licensee Jeff Miller		22. Name and Address of Facility JEFF MILLER P.C. FUNERAL HOME SERVICE 6639 N. BROADWAY BALTO. MD 21213		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SEIZURE DISORDER COMPLICATED BY HUMAN IMMUNODEFICIENCY VIRUS ENCEPHALITIS			
To Be Completed by Physician/Medical Examiner	23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			
State Registrar	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier [Signature]		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JULY 09, 1997			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R Penn Street, Baltimore, Maryland 21201		31. Date filed (Month, Day, Year) JUL 14 1997					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

97 21161

Certificate of Death

Reg. No.

DHH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Physician
/Medical
Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural," or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21162

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edna Mae Barnes				2. Date of Death Month July Day 10 Year 1997		3. Time of Death 12:14 am	
	4a. Facility Name (If not institution, give street and number) Union Memorial Hospital				4b. City, Town, or Location of Death Baltimore City		4c. County of Death NA	
Funeral Director	5. Social Security Number 217-20-3326		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 06-27-25	9. Birthplace (State or Foreign Country) Md.
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Md		10b. County NA		10c. City, Town or Location Baltimore		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 1202 Silver Thorne Road				10f. Zip Code 21239		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) NA		18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry in home			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) William Wallace				18. Mother's Name (First, Middle, Maiden Surname) Sally Wallace			
	19a. Informant's Name/Relationship (Type, Print) James Barnes				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1202 Silver Thorne Road Baltimore, Md. 21239			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Voshell Mem. Gardens		Date 07-14-97		20c. Location - City or Town, State Dundalk, Md.	
	21. Signature of Funeral Service Licensee Karen M. Kogen				22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue			
Physician /Medical Examiner	23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS Due to (or as a consequence of): TRICUSPID REGURGITATION Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Hypertension Diabetes mellitus							Approximate Interval Between Onset and Death 2 days 2 days
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Diabetes mellitus							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Kenneth G. Fulp, D.O.		29c. License number AT 2438946 M16		29d. Date signed (Month, Day, Year) July, 10, 1997		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kenneth G. Fulp, D.O. 17 Lincoln Woods Way 18 Perry Hall, MD 21128								
31. Date filed (Month, Day, Year) JUL 14 1997		32. Registrar's Signature [Signature]						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21163

Item 26 7-14-97 Film G749 W.H. Per Doctor

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Aaron

BROWN

2. Date of Death

Month Day Year
July 1, 1997

3. Time of Death

5:56 P.M.

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

218 10 0245

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year

2/27/20

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

2533 McHENRY ST.

10f. Zip Code

21223

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give

Year or Dates:

11/42

12/45

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: AMERICAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TRUCK DRIVER

16b. Kind of Business/Industry

(RETIRED)

WHITE COFFEE POT

17. Father's Name (First, Middle, Last)

ALVIN BROWN

18. Mother's Name (First, Middle, Maiden Surname)

BERTIE JONES

19a. Informant's Name/Relationship (Type, Print)

JOYCE C. BROWN (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2533 McHENRY ST. BALTO. MD. 21223

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST

Date

7/8/97

20c. Location - City or Town, State

OWINGS MILLS, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ESTEP BROTHERS FUNERAL HOME P.A.

1300 EUTAW PL. BALTO. MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Atherosclerotic Cardiovascular Disease

1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Insulin Dependent Diabetes Mellitus

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 27315

29d. Date signed (Month, Day, Year)

7-2-97

30. Name and address of person who completed cause of death (Item 28a) (Type, Print)

M L Fryenborg, MD

9000 Franklin Square Drive Baltimore, Maryland 21237

31. Date filed (Month, Day, Year)

JUL 14 1997

32. Registrar's Signature

Julia Davidson-Randall

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Items 26, 27, 31 7-14-97 Film G749 W.H. Per Doctor

97 21164

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Earl Bellamy

2. Date of Death

July

Day

2

Year

1997

3. Time of Death

1945

Funeral
Director

4a. Facility Name (If not institution, give street and number)

SAINT AGNES HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

5. Social Security Number

244-56-4470

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

56 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 4, 1940

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2121 Wicomico St.

10f. Zip Code

21230

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11th Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cutter

16b. Kind of Business/Industry

Decker Salvage

17. Father's Name (First, Middle, Last)

Earl Bellamy

18. Mother's Name (First, Middle, Maiden Summa)

Lillie Hilbert

19a. Informant's Name/Relationship (Type, Print)

Curtis Bellamy / Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21223 2761 W. Fairmount Ave. Baltimore, Maryland

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion Cemetery

Data

7/8

20c. Location - City or Town, State

Landsdowne, MD.

21. Signature of Funeral Service person

Kevin A. Parker

22. Name and Address of Facility

Kevin A. Parker Funeral Home

3512 Frederick Ave. Baltimore, Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ADENOCARCINOMA OF THE LUNG

Due to (or as a consequence of):

b. PERICARDIAL EFFUSION

Due to (or as a consequence of):

c. ATRIAL FIBRILLATION

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☒ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Radu S. Iancovici, M.D.

29c. License number

P010874

29d. Date signed (Month, Day, Year)

7/21/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Radu S. Iancovici, 900 Canton Ave, St Agnes Hosp, Baltimore

31. Date filed (Month, Day, Year)

7/21/97 JUL 14 1997

32. Registrar's Signature

Julia Davidson-Rendell

21229

State
Registrar

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

NAME: BELLAMY, EARL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97 21165

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Josephine Cosby				2. Date of Death Month JULY Day 6 Year 1997		3. Time of Death 12:07PM			
	4a. Facility Name (If not institution, give street and number) 1422 MAY COURT				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A			
Funeral Director	5. Social Security Number 218-36-0916		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 58 Yrs.		8. Date of Birth (Month, Day, Year) 9-3-38			
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE			
Usual Residence of Decedent										
10a. State MD			10b. County N/A			10c. City, Town or Location BALTIMORE				
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			10e. Street and Number 1422 MAY COURT			10f. Zip Code 21231		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DOMESTIC			16b. Kind of Business/Industry HOME MAKER				
17. Father's Name (First, Middle, Last) Edward Vincent					18. Mother's Name (First, Middle, Maiden Surname) ELLA GOINS					
19a. Informant's Name/Relationship (Type, Print) ESSIE TIMMONS SISTER					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2745 MATTHEWS ST. BALTO. MD.					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) VOSCHELL CEMETERY			20c. Date 7/11/97		20d. Location - City or Town, State BALTO. MD.		
21. Signature of Funeral Service Licensee Jeff Miller					22. Name and Address of Facility JEFF MILLER P.C. FUNERAL HOME + SERVICE 1639 N BROADWAY BALTO. MD.					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. Hypertensive Arteriosclerosis Due to (or as a consequence of):</p> <p>b. Coronary artery disease Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____ Due to (or as a consequence of):</p> </div> <div style="width: 35%; border-left: 1px solid black; padding-left: 5px;"> <p>Approximate Interval Between Onset and Death</p> </div> </div>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier Dr. J. Laron Locke MD					29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JULY 7, 1997			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201										
31. Date filed (Month, Day, Year) JUL 14 1997 <div style="text-align: right;">32. Registrar's Signature Julia Davidson-Randall</div>										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

**State
Registrar**

wlc
RASHAUN
COLEMANPlease Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97 21166

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Rashaun Alexandria Coleman				2. Date of Death Month Day Year July 10, 1997		3. Time of Death 135p	
	4a. Facility Name (If not institution, give street and number) 2842 POTEET STREET				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death NA	
Funeral Director	5. Social Security Number 000000	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 6 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Mar. 29, 1991		9. Birthplace (State or Foreign Country) Md
	Usual Residence of Decedent							
10a. State Md		10b. County NA		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 2311 Roslyn Ave				10f. Zip Code 21216		10g. Citizen of What Country? USA		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 Collage (1-4or 5+) NA				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Student			16b. Kind of Business/Industry School	
17. Father's Name (First, Middle, Last) Tschantee LeMonte Coleman				18. Mother's Name (First, Middle, Maiden Surname) Linda Carroll				
19a. Informant's Name/Relationship (Type, Print) Gail Arrington - Aunt				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9456 Ruffin Ridge Rd. Mechanicsville, VA 23116				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Md. Nat. Mem Park		20c. Location - City or Town, State Laurel, Md		
21. Signature of Funeral Service Licensee Blayne B. Harris				22. Name and Address of Facility March Funeral Home - West 4300 Wabash Ave. Balto Md 21215				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Shotgun Wound of Head Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
								24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year) 7-10-97		28b. Time of Injury 1126 M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28d. Describe how injury occurred Subject shot		28e. Location (Street and Number or Rural Route Number, City or Town, State) 2842 Poteet St. 21215		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier J. Laron Locke				
				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) July 11, 1997		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) J. Laron Locke, MD 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) JUL 14 1997				32. Registrar's Signature Julia Jackson-Randall				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

WRC
97-3796-510
TSCHANTRE L.
COLEMAN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21167

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) TSCHANTRÉ LeMONTE COLEMAN				2. Date of Death Month JULY Day 10 Year 1997		3. Time of Death 1:35 PM.		
	4a. Facility Name (If not institution, give street and number) 2842 POTEET ST.				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death NA		
Funeral Director	5. Social Security Number 251-29-9855		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 39 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 10, 1958	9. Birthplace (State or Foreign Country) Md	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Md		10b. County NA		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 2842 POTEET STREET				10f. Zip Code 21225		10g. Citizen of What Country? United States		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) NA			16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter			16b. Kind of Business/Industry Cabinet Shop		
	17. Father's Name (First, Middle, Last) Leonard Coleman				18. Mother's Name (First, Middle, Maiden Surname) Mary Godsey				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Gail Arington - Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9456 Ruffin Ridge Rd. Mechanicsville, VA 23116				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metairie Crematory		Date 7-12-97		20c. Location - City or Town, State Balto. Md		
	21. Signature of Funeral Service Licensee Thymin B. Starni				22. Name and Address of Facility March Funeral Home - West 4300 Wabash Ave Balto. Md 21215				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Contest Shotgun Wound of Head Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 7-10-97		28b. Time of Injury 1126 M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Subject shot self	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) AT HOME		28f. Location (Street and Number or Rural Route Number, City or Town, State) 2842 Poteet St. 21215					
29b. Signature and title of certifier Thymin B. Starni				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JULY 11, 1997			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) JARON WIFE, MD 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) JUL 14 1997		32. Registrar's Signature Julia Davidson-Randall							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

97-3759-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

JUANITA

State of Maryland / Department of Health and Mental Hygiene

97 21168

CALLOWAY Items: 23a part I, 27 per MEO G-749 7/30/97 Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

JUANITA CALLOWAY

2. Date of Death

Month
JULYDay
8Year
1997

3. Time of Death

6:46 P.M.

4e. Facility Name (If not institution, give street and number)

UNION MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

215-92-3080

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

24

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

JUL 1, 1973

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTO

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

501 E. PRESTON ST APT 625

10f. Zip Code

21202

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

N/A

16. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

WAITRESS

16b. Kind of Business/Industry

RESTAURANT

17. Father's Name (First, Middle, Last)

NATHANIEL CALLOWAYS

18. Mother's Name (First, Middle, Maiden Surname)

JANIE NEWKIRK

19a. Informant's Name/Relationship (Type, Print)

JANNIE CAOLLOWAY

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1419 ENSOR ST BALTO, MD 21202

20a. Method of Disposition

1 ☒ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

MT. ZION CEM

Date

JUL 12, 1997

20c. Location - City or Town, State

BALTO, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

BETTS FUNERAL HOME

1129 N. CAROLINE ST BALTO, MD 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. MYOCARDITIS

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JULY 9, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David R Fowler

111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

JUL 14 1997

32. Registrar's Signature

John Anderson-Randall

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "Natural" or "Accident", the Medical Examiner must be notified at
502-63-5000.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21169

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William Taft Carson

2. Date of Death

Month Day Year
July 11, 1997

3. Time of Death

3:10 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

4913 Forge Road

4b. City, Town, or Location of Death

Perry Hall

4c. County of Death

Baltimore

5. Social Security Number

213-07-9198

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

88

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept. 11, 1908

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Perry Hall

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

4913 Forge Road

10f. Zip Code

21128

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8 Years

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Die Setter

16b. Kind of Business/Industry

Steel Industry

17. Father's Name (First, Middle, Last)

George Washington Carson

18. Mother's Name (First, Middle, Maiden Surname)

Mary Sisler

19a. Informant's Name/Relationship (Type, Print)

Mrs. Sharon E. Wollschlager

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4913 Forge Road Perry Hall, Maryland 21128

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Oak Lawn Cemetery 7/14/1997

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Johnny B. Bida

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Colon Cancer with liver metastases

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ronald Thomas MD

29c. License number

D26318

29d. Date signed (Month, Day, Year)

7/11/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

3004 Emmorton Road Abingdon, Md. 21009

Ronald Thomas, MD

31. Date filed (Month, Day, Year)

JUL 14 1997

32. Registrar's Signature

John B. Bida

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21170

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Cunningham

2. Date of Death

Month Day Year
June 29 1997

3. Time of Death

2:09 AM

4a. Facility Name (If not institution, give street and number)

Harbor Hospital Center 3001 Hanover Street Baltimore

4b. City, Town, or Location of Death

4c. County of Death

N/A

5. Social Security Number

214-18-6968

6. Sex

M 2 F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
January 27, 1917

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

3010 ASCENSION ST.

10f. Zip Code

21225

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

1 Yes 2 No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: AFR. AMERICAN

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

TRUCK DRIVER

16b. Kind of Business/Industry

FREIGHT CO.

17. Father's Name (First, Middle, Last)

BENSON CUNNINGHAM

18. Mother's Name (First, Middle, Maiden Surname)

FARAH GILMORE

19a. Informant's Name/Relationship (Type, Print)

FRANCES CUNNINGHAM (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3010 ASCENSION ST. BALTO. MD 21225

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

GARRISON FOREST V.A. CEM. 7/3/97

Date

20c. Location - City or Town, State

OWINGS MILL MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ESTEP BROTHERS FUNERAL HOME P.A.
1300 EUTAW PLACE BALTO. MD 21217

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

a. Hypoxemia
Due to (or as a consequence of):

b. Chronic obstructive lung disease
Due to (or as a consequence of):

c. Pulmonary Hypertension
Due to (or as a consequence of):

d. Exposure to Asbestos in Pulmonary Ca

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy
performed?

1 Yes 2 No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1 Yes 2 No

25. Was case referred to medical
examiner?

1 Yes 2 No

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

5 Pending investigation

6 Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier
(Check only one)

1 Certifying Physician

2 Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

403 E. PATTERSON CO. BALTO. MD 21225

31. Date filed (Month, Day, Year)

JUL 14 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 22 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the medical examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21171

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Daniel Chesney				2. Date of Death Month July Day 10 Year 1997		3. Time of Death 14:51	
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death City	
Funeral Director	5. Social Security Number 216-66-8651		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 40 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 11, 1956	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Carroll		10c. City, Town or Location Hampstead	
Usual Residence of Decedent								
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
10e. Street and Number 1440 N. Main Street				10f. Zip Code 21074		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sergeant		16b. Kind of Business/Industry Baltimore County Police Dept.		
17. Father's Name (First, Middle, Last) Bobby Ray Chesney, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Alice Marion McConaughy				
19a. Intomment's Name/Relationship (Type, Print) Darryl J. Chesney - brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2008 Hanover Pike, Hampstead, Md. 21074				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem. Gardens		20c. Location - City or Town, State July 14, 1997 Timonium, Md.		
21. Signature of Funeral Service Licensee J. South Eckhardt				22. Name and Address of Facility Eckhardt Funeral Chapel 3296 Charmil Dr. Manchester, Md. 21102				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e. multisystem organ failure Due to (or as a consequence of):								12 hrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. heart failure after cardiac transplantation Due to (or as a consequence of):								16 hrs
c. _____ Due to (or as a consequence of):								
d. _____ Due to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Elaine Tseng MD Surgery Resident				29c. License number RES-000		29d. Date signed (Month, Day, Year) July 10, 1997		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Blalock 618 Johns Hopkins Hospital				600 N. Wolfe St. Baltimore MD 21287				
31. Date filed (Month, Day, Year) JUL 14 1997				32. Registrar's Signature Julia Davidson-Randall				

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research. The second part of the report is a detailed description of the methods used in the study. This includes a discussion of the experimental design, the data collection procedures, and the statistical methods used to analyze the data.

3. The third part of the report is a discussion of the results of the study. This includes a presentation of the data and a discussion of the findings. The fourth part of the report is a conclusion and a summary of the main points of the study. This includes a discussion of the implications of the findings and a recommendation for further research.

5. The fifth part of the report is a list of references. This includes a list of the books, articles, and other sources used in the study. The sixth part of the report is an appendix. This includes a list of the tables, figures, and other supplementary material used in the study.

7. The seventh part of the report is a list of abbreviations. This includes a list of the abbreviations used in the study. The eighth part of the report is a list of symbols. This includes a list of the symbols used in the study.

9. The ninth part of the report is a list of footnotes. This includes a list of the footnotes used in the study. The tenth part of the report is a list of endnotes. This includes a list of the endnotes used in the study.

11. The eleventh part of the report is a list of appendices. This includes a list of the appendices used in the study. The twelfth part of the report is a list of references. This includes a list of the references used in the study.

13. The thirteenth part of the report is a list of symbols. This includes a list of the symbols used in the study. The fourteenth part of the report is a list of abbreviations. This includes a list of the abbreviations used in the study.

15. The fifteenth part of the report is a list of footnotes. This includes a list of the footnotes used in the study. The sixteenth part of the report is a list of endnotes. This includes a list of the endnotes used in the study.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21172

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Ellis Denny				2. Date of Death Month Day Year July 9, 1997		3. Time of Death 1:15 A.M.	
	4a. Facility Name (If not institution, give street and number) Villa Assumpta 6401 N. Charles Street				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 031-16-3887		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 70 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 4, 1926	
	9. Birthplace (State or Foreign Country) Massachusetts		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore	
Usual Residence of Decedent								
10a. State Maryland			10b. County Baltimore			10c. City, Town or Location Baltimore		
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			10e. Street and Number 6401 N. Charles Street			10f. Zip Code 21212		
10g. Citizen of What Country? U.S.A.			11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 5+ years		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administration			16b. Kind of Business/Industry High School-Education			17. Father's Name (First, Middle, Last) Ellis Denny		
18. Mother's Name (First, Middle, Maiden Surname) Margaret Lynch			19a. Informant's Name/Relationship (Type, Print) Bernice Feilinger, S.S.N.D.			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6401 N. Charles St. Baltimore, Maryland 21212		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Villa Maria Cemetery			20c. Location - City or Town, State 7-12-97 Glen Arm, Maryland		
21. Signature of Funeral Service Licensee George J. Fennell			22. Name and Address of Facility Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212			23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CANCER OF COLON Due to (or as a consequence of): a. CANCER OF COLON Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		
28a. Date of Injury (Month, Day Year)			28b. Time of Injury M			28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier Alberto Diaz			29c. License number 204126		
29d. Date signed (Month, Day, Year) 7/9/97			30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Alberto Diaz, M.D. 7401 Osler Drive Towson, Maryland 21204			31. Date filed (Month, Day, Year) JUL 14 1997		
32. Registrar's Signature Julian Davidson-Randall								

Baltimore, Maryland 21215-0028

permit. Pages 1 and 2 should be filled within 72 hours and death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or "homicide," or "suicide," or "accident," or "pending investigation," or "could not be determined," or "other," the Medical Examiner must be notified at 9058.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21173

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) OLLIE L. DICKERSON				2. Date of Death Month Day Year JULY 11 1997		3. Time of Death 4:15 A.M.	
	4a. Facility Name (If not institution, give street and number) 605 N. LOUDON AVENUE				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 219 03 1324A		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 94 Yrs.		8. Date of Birth (Month, Day, Year) JUN. 27. 1903	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MD.		10b. County N/A		10c. City, Town or Location BALTIMORE	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 605 N. LOUDON AVENUE				10f. Zip Code 21229		10g. Citizen of What Country? U.S. OF A.	
To Be Completed by Physician/Medical Examiner	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DOMESTIC WORKER		16b. Kind of Business/Industry PRIVATE FAMILIES			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) CLARENCE DICKERSON				18. Mother's Name (First, Middle, Maiden Surname) ADELL ANDERSON			
	19a. Informant's Name/Relationship (Type, Print) NAOMI F. TULL (DAUGHTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 605 N. LOUDON AVE. BALTIMORE MD. 21229			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ARBUTUS MEM. PK. 7/15/97		Date BALTIMORE MARYLAND		20c. Location - City or Town, State	
	21. Signature of Funeral Service Licensee Lewis T. Gwynn		22. Name and Address of Facility LEWIS T. GWYNN FUNERAL HOME 21215-6393 4517 PARK HEIGHTS AVE. BALTO., MD.					
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Widely METASTATIC INTRA-ABDOMINAL Malignancy 2 years Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred						28e. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier ATTENDING				29c. License number D16200		29d. Date signed (Month, Day, Year) July 14, 1997	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. N. M. MACHIRAN 720-C MAIDEN CHOICE LA., CATOWSVILLE, MD, 21228							
State Registrar	31. Date filed (Month, Day, Year) JUL 14 1997				32. Registrar's Signature John Davidson-Randall			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or "pending investigation," any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

GROSS EMACIATION. MITRAL INSUFFICIENCY

Senile Emphysema. Early PARKINSON'S DISEASE

ASP
97-3685-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21174

CLEAVON DURANT

Items: 23 a part 1, 27, 28a-f per MEO G-749 7/14/97 dh Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CLEAVON DURANT				2. Date of Death Month JULY Day 04 Year 1997				3. Time of Death 7:00 A						
	4a. Facility Name (If not institution, give street and number) 5528 WHITWOOD RD.				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death N/A						
Funeral Director	5. Social Security Number 218 70 7373		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 39 Yrs.		8. Date of Birth (Month, Day, Year) 7/2/58		9. Birthplace (State or Foreign Country) MD.						
	Usual Residence of Decedent														
To Be Completed by Funeral Director	10a. State MD.		10b. County N/A		10c. City, Town or Location BALTIMORE				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
	10e. Street and Number 5528 WHITWOOD ROAD				10f. Zip Code 21206		10g. Citizen of What Country? USA								
	11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: AFRO AMERICAN						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) FORM ANALYST				16b. Kind of Business/Industry ZURICH INS. CO.						
	17. Father's Name (First, Middle, Last) TOM DURANT				18. Mother's Name (First, Middle, Maiden Surname) DOROTHY MAE DURANT										
	19a. Informant's Name/Relationship (Type, Print) KAREN A. DURANT WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5528 WHITWOOD ROAD BALTO. MD. 21206										
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) WOODLAWN MEM. PARK		Date 7/9/97		20c. Location - City or Town, State BALTO. MD.								
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PL. BALTO. MD. 21217										
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. NARCOTIC INTOXICATION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
										24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
										24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) found 7/4/97		28b. Time of Injury found 6:45^M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred unknown					
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) at residence				28f. Location (Street and Number or Rural Route Number, City or Town, State) 5528 Whitwood Road, Baltimore, Maryland							
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier <i>Theodore M. King</i>		29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) JULY 04, 1997	
30. Name and address of person who completed cause of death (Form 23a) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201															
31. Date filed (Month, Day, Year) JUL 14 1997										32. Registrar's Signature <i>Julia Davidson-Rendella</i>					

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21175

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROSCOE EVANS				2. Date of Death Month July Day 12 Year 1997		3. Time of Death 1:30 P	
	4a. Facility Name (If not institution, give street and number) Mercy/Stella Maris				4b. City, Town, or Location of Death Baltimore		4c. County of Death n/a	
Funeral Director	5. Social Security Number 220-22-6362		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 67 Yrs.		8. Date of Birth (Month, Day, Year) July 23, 1929	
	9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County n/a		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 2233 Reisterstown Rd.		10f. Zip Code 21217	
	10g. Citizen of What Country? USA				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+) College	
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Postal Worker				16b. Kind of Business/Industry U.S. Post Office			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) John Henry Evans				18. Mother's Name (First, Middle, Maiden Surname) Drucilla A.			
	19a. Informant's Name/Relationship (Type, Print) Dorothy Evans/wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7929 Freetown Rd. Pasadena, MD 21060			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		20c. Location - City or Town, State 7/14 Catonsville, MD	
	21. Signature of Funeral Service Licensee James G. Morton				22. Name and Address of Facility James A. Morton & Sons Funeral Home 1701 Laurens St. Balto., MD 21217			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. BRAIN METASTASIS Due to (or as a consequence of): b. LUNG CANCER Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 4 months 7 months				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
	23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) STELLA MARIS AT MEACH HOSPICE				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day Year)				28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Dr. [Signature]			
	29c. License number 240480				29d. Date signed (Month, Day, Year) July 14, 1997			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FERNANDO J. FERRO, MD				31. Data filed (Month, Day, Year) JUL 14 1997			
	32. Registrar's Signature Julia Davidson-Randall				33. Registrar's Title MD 21206			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21176

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ETHEL LEE SHELLY FENTRESS				2. Date of Death Month Day Year 07 09 97		3. Time of Death 09:30pm	
	4e. Facility Name (If not institution, give street and number) LAUREL REGIONAL HOSPITAL				4b. City, Town, or Location of Death LAUREL		4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 430-05-3240		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) May 22, 1911	
	9. Birthplace (State or Foreign Country) Little Rock, AR		10a. State IL		10b. County n/a		10c. City, Town or Location Chicago	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 1520 N. Wieland Street		10f. Zip Code 60610		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade		College (1-4 or 5+) NA		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Factory Worker		16b. Kind of Business/Industry Factory	
	17. Father's Name (First, Middle, Last) Richard Shelly		18. Mother's Name (First, Middle, Maiden Surname) Clara Smith		19a. Informant's Name/Relationship (Type, Print) Marie McDaniel - Grand-daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6979 Mayfair Terrace, Laurel, MD 20707	
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Burr Oak Cem		Date 7-13-97		20c. Location - City or Town, State Illinois	
	21. Signature of Funeral Service Licensee Gladys Wanes		22. Name and Address of Facility Mark F. H. West 4300 Wabash Avenue Baltimore MD 21215		23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MULTIPLE INJURIES Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death	
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 07-09-97		28b. Time of Injury 09:00pm		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred OCCUPANT OF AUTO VS PICKUP TRUCK COLLISION		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) STREET		28f. Location (Street and Number or Rural Route Number, City or Town, State) RT 198 & VAN DUSEN RD, LAUREL		29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	29b. Signature and title of certifier DME		29c. License number D 33954		29d. Date signed (Month, Day, Year) JULY 11, 1997		30. Name and address of person who completed cause of death (from 23e) (Type, Print) MARIO F. GOLUE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785	
State Registrar	31. Date filed (Month, Day, Year) JUL 14 1997		32. Registrar's Signature Julia Davidson-Randall					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 21177**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SALLY L. FOREMAN

2. Date of Death

Month
7Day
10Year
97

3. Time of Death

3:30 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

MARYLAND GENERAL HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

5. Social Security Number

219-30-9908-A

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

02-17-02

9. Birthplace (State or Foreign Country)

N.C.

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5200 Kenilworth Avenue

10f. Zip Code

21212

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Private Families

17. Father's Name (First, Middle, Last)

William Louis Carson

18. Mother's Name (First, Middle, Maiden Surname)

Vinnie Staley

19a. Informant's Name/Relationship (Type, Print) sister
Phyllis M. Bagwell19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5200 Kenilworth Avenue Baltimore, Md. 21212

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Memorial Park

Date

July 16 Baltimore County, Md.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Nutter Funeral Homes, Inc.
2501 Gwynns Falls PKWY Baltimore, Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. CHF (Congestive Heart Failure)

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. PNEUMONIA

Due to (or as a consequence of):

c. Diabetes

Due to (or as a consequence of):

d. Left ventricular hypertrophy with dysfunction

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Peripheral vascular disease
Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Nalanda Chaudhary (INTERN)

29c. License number

D31464

29d. Date signed (Month, Day, Year)

7/10/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

SHARON A. HASTON, MD 821 N. Euton St Suite 308, Balt. MD 21201

State
Registrar

31. Date filed (Month, Day, Year)

JUL 14 1997

32. Registrar's Signature

Julia Davidson-Randall

Baltimore, Maryland 21215-0020
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21178

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOSEPH FEATHERSTONE				2. Date of Death Month JULY Day 7 Year 97		3. Time of Death 1512	
	4a. Facility Name (If not institution, give street and number) University Of Maryland Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death NA	
Funeral Director	5. Social Security Number 239-20-1899		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) 11-27-19	
	9. Birthplace (State or Foreign Country) VA		10a. State MD		10b. County NA		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 765 McKewin Avenue		10f. Zip Code 21218		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th Grade College (1-4 or 5+) NA		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sanitation Driver		16b. Kind of Business/Industry Baltimore City		17. Father's Name (First, Middle, Last) Willie Featherstone		
18. Mother's Name (First, Middle, Maiden Surname) Ella Miles		19a. Informant's Name/Relationship (Type, Print) Faybell Featherstone		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 765 McKewin Avenue Baltimore, Maryland 21218		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Mem. Pk. Cem. 07-12-97 Arbutus, Md.		20c. Location - City or Town, State		21. Signature of Funeral Service Licensee Vanessa Cond		22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CEREBRAL VASCULAR ACCIDENT Due to (or as a consequence of): b. HYPERTENSION Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 48 HOURS 20 YEARS		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PERIPHERAL VASCULAR DISEASE PREVIOUS MYOCARDIAL INFARCTION		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		
29b. Signature and title of certifier MD		29c. License number XU4176435 C66E		29d. Date signed (Month, Day, Year) JUL 7th 1997		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COOK JYPSON H MD 118 W. OSNEY AVE BALTIMORE MD 21230		
31. Date filed (Month, Day, Year) JUL 14 1997		32. Registrar's Signature John Davidson-Randall		33. Registrar's Title Registrar		34. Registrar's Office State Registrar		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

97 21179

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ELEANOR J. FLOYD				2. Date of Death Month JULY Day 10 Year 1997		3. Time of Death 2:10 AM	
	4a. Facility Name (If not institution, give street and number) NORTH ARUNDEL HOSPITAL				4b. City, Town, or Location of Death GLEN BURNIE		4c. County of Death ANNE ARUNDEL	
Funeral Director	5. Social Security Number 218 07 7994		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 11, 1914	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 602 Surfside Avenue		10f. Zip Code 21225		10g. Citizen of What Country? U.S.	
	11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Maker		16b. Kind of Business/Industry Own Home		17. Father's Name (First, Middle, Last) Ottavio C. Ormanno	
	18. Mother's Name (First, Middle, Maiden Surname) Josephine Costa		19a. Informant's Name/Relationship (Type, Print) Laura E. Evans / daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 605 Biscay Avenue Baltimore, Maryland 21225		20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) Entombment	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		20c. Date 7/12/97		20d. Location - City or Town, State Baltimore, Maryland		21. Signature of Funeral Service Licensee Donna M. Braniewski	
	22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225		23. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ARDS Due to (or as a consequence of): b. PANCREATITIS Due to (or as a consequence of): c. SEPTIC - Ancient SEPTICEMIA Due to (or as a consequence of): d. GBLSSING		Approximate Interval Between Onset and Death		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	29b. Signature and title of certifier Dr. Kora M.D.		29c. License number 042219		29d. Date signed (Month, Day, Year) 7/10/97		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KORA, E.O. 4306 PINEFIELD CT, NORTON, MD 21133.	
To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) JUL 14 1997		32. Registrar's Signature John D. ...		33. Date of Death 7/10/97		34. Time of Death 2:10 AM	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21180

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Benjamin Fleet				2. Date of Death Month Day Year 07-04-97		3. Time of Death 9:00AM	
	4a. Facility Name (If not institution, give street and number) BAY AREA HOSPICE				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 213-09-7153	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 8/1/10		9. Birthplace (State or Foreign Country) MD.
	Usual Residence of Decedent							
10a. State MD.		10b. County N/A		10c. City, Town or Location BALTIMORE			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 2611 HOLLIN FERRY ROAD				10f. Zip Code 21230		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 12/42 10/45		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. AFRO Specify: AMERICAN		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Boilerman (RETIRED)		16b. Kind of Business/Industry MD. GLASS CO.		
17. Father's Name (First, Middle, Last) BENJAMIN FLEET SR.				18. Mother's Name (First, Middle, Maiden Surname) KATHERINE JACKSON				
19a. Informant's Name/Relationship (Type, Print) BRENDA F. JOHNSON DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 225 BOLIVAR AVE. BALTIMORE, MD. 21225				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CROWNSVILLE, V.A.		Date 7/10/97		20c. Location - City or Town, State CROWNSVILLE, MD.		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PL. BALTO. MD. 21217				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Prostate Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 15 months
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 						
		29c. License number 924149		29d. Date signed (Month, Day, Year) 7/7/97				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dorothy A. Snow, M.D., 10 N. Greene St., Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) JUL 14 1997		32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 28a or 28d show any injury or other traumatic event, the Medical Examiner will be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State
Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21181

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) NORMAN FONSECA				2. Date of Death Month Day Year JULY 09, 1997		3. Time of Death 0105AM	
	4a. Facility Name (If not institution, give street and number) UNIVERSITY HOSPITAL S.T.U.				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death	
Funeral Director	5. Social Security Number 217-66-6884		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 39 Yrs.		8. Date of Birth (Month, Day, Year) AUG 26, 1957	
	9. Birthplace (State or Foreign Country) BALTIMORE, MD.		10e. State MARYLAND		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE	
To Be Completed by Funeral Director	10a. Street and Number 1934 PENROSE AVE.		10f. Zip Code 21223		10g. Citizen of What Country? USA		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: AFRO.AMERICAN	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BEVERAGES COMPANY		16b. Kind of Business/Industry BOTTLERS		17. Father's Name (First, Middle, Last) LEROY PAGIE	
	18. Mother's Name (First, Middle, Maiden Surname) AUDREY FONSECA		19a. Informant's Name/Relationship (Type, Print) AUDREY FONSECA MOTHER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1111 W. MOSHER STREET, BALTIMORE, MARYLAND 21217		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) NEW CATHEDRAL CEMETERY		20c. Date 7/14/97		20d. Location - City or Town, State BALTIMORE, MARYLAND		21. Signature of Funeral Service Licensee <i>Lloyd M. Oster</i>	
	22. Name and Address of Facility ESTEP BROTHERS FUNERAL HOME, P.A. 1300 EUTAW PLACE, BALTIMORE, MARYLAND 21217		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Multiple Gunshot Wounds		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year) 7-9-97		28b. Time of Injury 0010 M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred subject shot	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Street		28f. Location (Street and Number or Rural Route Number, City or Town, State) 1800 Pennsylvania Ave		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>	
	29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JULY 09, 1997		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dan R Fowler 111 Penn Street, Baltimore, Maryland 21201		31. Date filed (Month, Day, Year) JUL 14 1997	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 21182

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM FLOYD GILBERT				2. Date of Death Month July Day 11 Year 1997		3. Time of Death 1:10 P.M.	
	4e. Facility Name (If not institution, give street and number) Greater Baltimore Medical Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 167-09-8660		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 9, 1910	9. Birthplace (State or Foreign Country) Pennsylvania
	Usual Residence of Decedent							
10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 218 E. Lake Avenue				10f. Zip Code 21212		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years College (1-4or 5+) College				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) General Claim Agent			16b. Kind of Business/Industry Railroad	
17. Father's Name (First, Middle, Last) Lee Wolsley Gilbert				18. Mother's Name (First, Middle, Maiden Surname) Martha Milligan				
19a. Informant's Name/Relationship (Type, Print) William F. Gilbert (son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1909 Winchester Rd. Toledo, Ohio 43613				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery		Date 7-15-97		20c. Location - City or Town, State Woodlawn, Maryland		
21. Signature of Funeral Service Licensee <i>George J. Fername</i>				22. Name and Address of Facility Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212				
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Pneumonia Due to (or as a consequence of): Esophageal Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Asbestosis</i>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>W. J. ...</i>		29c. License number 15584		29d. Date signed (Month, Day, Year) 7 13 97		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Eddie Nakhuda, M.D. 2300 Dulany Valley Rd Timonium, Md 21093								
31. Date filed (Month, Day, Year) JUL 14 1997		32. Registrar's Signature <i>John ...</i>						

Baltimore, Maryland 21215-6020
permit. Pages 1 and 2 should be filed within 24 hours of death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21183

Item 26 7-14-97 Film 6749 W.H. Per Doctor

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dolores T. Goodson				2. Date of Death Month July Day 4 Year 1997		3. Time of Death 3:48 PM	
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview Medical Ctr.				4b. City, Town, or Location of Death Baltimore City		4c. County of Death N/A	
Funeral Director	5. Social Security Number 214-26-1241		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 67 Yrs.		8. Date of Birth (Month, Day, Year) June 26, 1930	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Dundalk	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 4136 Eder Road		10f. Zip Code 21222	
	10g. Citizen of What Country? United States				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 Years College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home		17. Father's Name (First, Middle, Last) Stanley Iszkewicz	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) Helen Scztinska				19a. Informant's Name/Relationship (Type, Print) Mr. Clyde M. Goodson/Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4136 Eder Road Dundalk, MD 21222	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) St. Stanislaus Cemetery 7/8/1997		20c. Location - City or Town, State Dundalk, Maryland	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Gregory E. Reed				22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Cardiac Arrest Due to (or as a consequence of): b. Hypertensive Cardiovascular Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) 7/7/97			
To Be Completed by Physician/Medical Examiner	28b. Time of Injury M				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and Title of certifier Gregory E. Reed			
	29c. License number D22723				29d. Date signed (Month, Day, Year) 7/7/97			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4920 Campbell Blvd. White Marsh MD 21236				31. Date (Month, Day, Year) JUL 14 1997			
	32. Date of Death (Month, Day, Year) JUL 14 1997				33. Date of Death (Month, Day, Year) JUL 14 1997			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

5

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21184

Item 29D 7-14-97 Film G749 W.H. Per Doctor

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HERMAN A GRABOYES				2. Date of Death Month Day Year July 3, 1997		3. Time of Death 9:35 a.m.	
	4e. Facility Name (If not institution, give street and number) STELLA MARIS HOSPICE				4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 165-12-0262		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) JAN 2, 1921	
	9. Birthplace (State or Foreign Country) PENNSYLVANIA		10a. State MD		10b. County BALTIMORE		10c. City, Town or Location TOWSON	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number 108 KENILWORTH PARK DR., APT. 2-A				10f. Zip Code 21204		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SR. VICE PRESIDENT		16b. Kind of Business/Industry ATLAS STEEL RULE & DYE CO.			
	17. Father's Name (First, Middle, Last) JACOB GRABOYES				18. Mother's Name (First, Middle, Maiden Surname) FRIEDA AXELROD			
	19e. Informant's Name/Relationship (Type, Print) SANDRA GLASSNER (DAUG.)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 304 HIGH MEADOW RD. REISTERSTOWN, MD 21136			
	20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HAR JEHUDA		Date 7/6/97		20c. Location - City or Town, State UPPER DARBY, PA	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208			
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Lung Cancer Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) HOSPICE			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier 				29c. License number 033215		29d. Date signed (Month, Day, Year) July 3, 1997	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. SHIRLEY THOMPSON-RICHARDS 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093							
31. Date filed (Month, Day, Year) JUL 14 1997								
32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21185

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) IRVIN HAZELL				2. Date of Death Month JULY Day 09 Year 1997		3. Time of Death 20:30									
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death									
Funeral Director	5. Social Security Number 214-64-8069	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 41 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, Year Nov. 12, 1955	9. Birthplace (State or Foreign Country) Maryland									
	Usual Residence of Decedent															
To Be Completed by Funeral Director	10a. State Maryland	10b. County N/A	10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No											
	10e. Street and Number 3 South Chester St.		10f. Zip Code 21231		10g. Citizen of What Country? USA											
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. African American										
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Social Worker		16b. Kind of Business/Industry Balto. City Health Dept.											
	17. Father's Name (First, Middle, Last) Richard Hazell		18. Mother's Name (First, Middle, Maiden Surname) Lucille Williams													
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) (sister) Ms. Barbara Evans		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 624 W. Franklin St. Apt. 6 Balto, Md. 21201													
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion		20c. Location - City or Town, State 7/16/97 Lansdowne, Md.											
	21. Signature of Funeral Service Licensee Joseph L. Russ		22. Name and Address of Facility Joseph L. Russ Funeral Home 2332 W. North Ave. Balto, Md. 21216													
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
	<table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Nocardia Pneumonia Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death 3 months</td> </tr> <tr> <td rowspan="3">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. HIV-AIDS CD4-1 Due to (or as a consequence of):</td> <td>5 years</td> </tr> <tr> <td>c. Thrombocytopenia Due to (or as a consequence of):</td> <td>2 weeks</td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>							Immediate Cause (Final disease or condition resulting in death)	a. Nocardia Pneumonia Due to (or as a consequence of):	Approximate Interval Between Onset and Death 3 months	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. HIV-AIDS CD4-1 Due to (or as a consequence of):	5 years	c. Thrombocytopenia Due to (or as a consequence of):	2 weeks	d.
Immediate Cause (Final disease or condition resulting in death)	a. Nocardia Pneumonia Due to (or as a consequence of):	Approximate Interval Between Onset and Death 3 months														
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. HIV-AIDS CD4-1 Due to (or as a consequence of):	5 years														
	c. Thrombocytopenia Due to (or as a consequence of):	2 weeks														
	d.															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CMV RETINITIS CNS TOXOPLASMOSIS ANEMIA						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No										
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred														
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.														
29b. Signature and title of certifier Manish Sagar		29c. License number RESF 000		29d. Date signed (Month, Day, Year) July 07, 1997												
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MANISH SAGAR JOHNS HOPKINS HOSPITAL TOWER 110 BALTIMORE, MD 21205																
31. Date filed (Month, Day, Year) JUL 14 1997		32. Registrar's Signature Julia Davidson-Rendell														

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

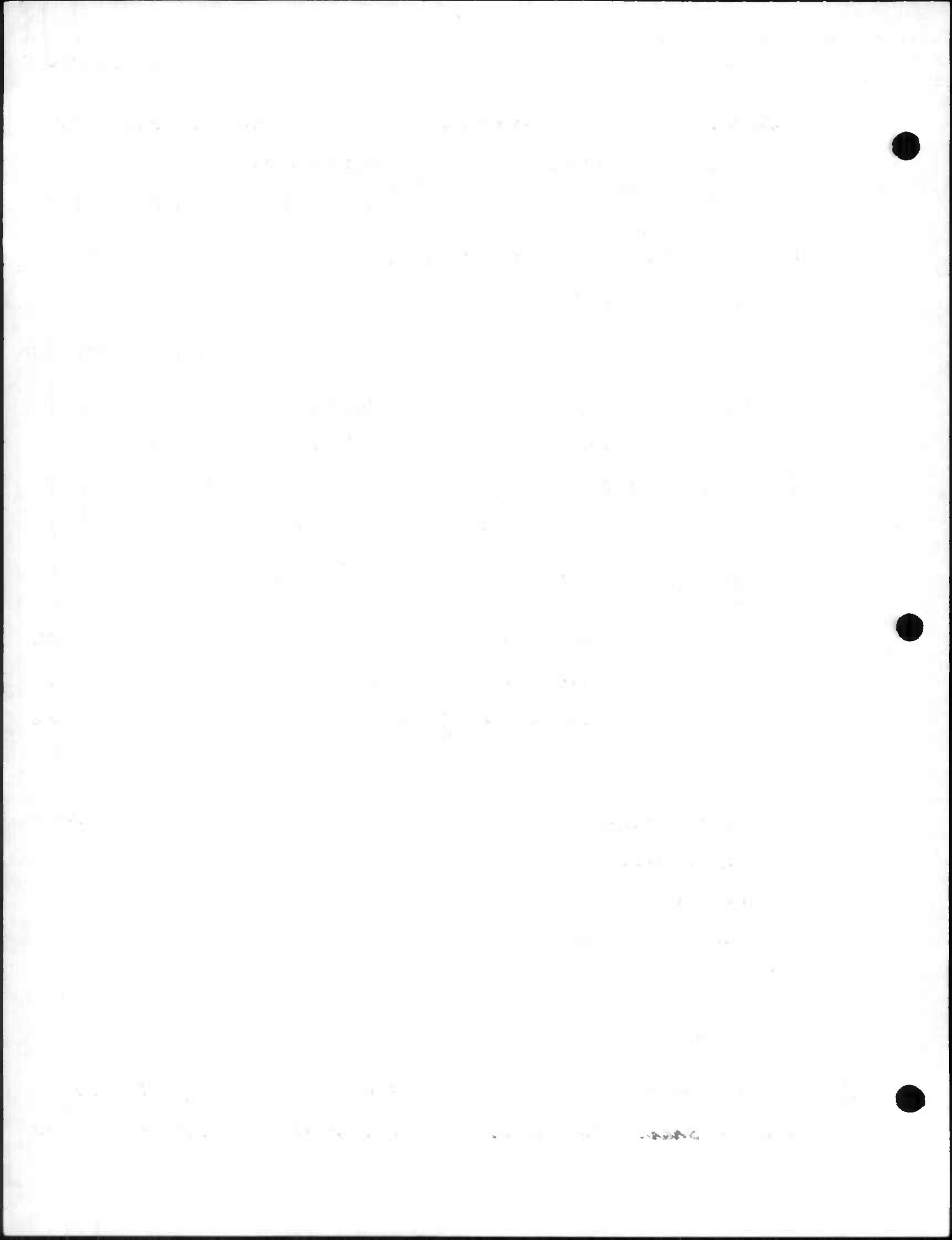
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21186

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Alice Hoover

2. Date of Death

Month
JulyDay
11Year
1997

3. Time of Death

10:00 am

4a. Facility Name (If not institution, give street and number)

4616 Water Tank Rd.

4b. City, Town, or Location of Death

Manchester

4c. County of Death

Carroll

Funeral
Director

5. Social Security Number

215-26-8868

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept. 11, 1930

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Manchester

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4616 Water Tank Rd.

10f. Zip Code

21102

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
11College (1-4 or 5+)
4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Elementary School

17. Father's Name (First, Middle, Last)

Henry Houck Warner

18. Mother's Name (First, Middle, Maiden Surname)

Mary Snyder

19a. Informant's Name/Relationship (Type, Print)

Stanley Hoover - husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4616 Water Tank Rd. Manchester, Md. 21102

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lazarus Church Cem. July 14, 1997 Lineboro, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

James Scott Eckhardt

22. Name and Address of Facility

Eckhardt Funeral Chapel
3296 Charmil Dr. Manchester, Md. 21102

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Acromegaly

Due to (or as a consequence of)

Approximate Interval Between Onset and Death

20 yrs

b.

Pituitary Tumor

Due to (or as a consequence of)

20 yrs

c.

Due to (or as a consequence of)

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension aortic + Mitral Insufficiency

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

W H Foard MD

29c. License number

D02386

29d. Date signed (Month, Day, Year)

7/12/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W H Foard MD 3223 MAIN ST MANCHESTER, MD 21102

31. Date filed (Month, Day, Year)

JUL 14 1997

32. Registrar's Signature

John Davidson-Randall

State
RegistrarBaltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than Natural, or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21187

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HARRY L. JOHNSON JR.			2. Date of Death Month Day Year July 7, 1997		3. Time of Death 957 AM	
	4a. Facility Name (If not Institution, give street and number) MARYLAND GENERAL HOSPITAL			4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death N/A	
Funeral Director	5. Social Security Number 212-20-6795		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 25, 1925
	10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
10e. Street and Number 1100 Bolton St. Apt. 1007							
10f. Zip Code 21201							
10g. Citizen of What Country? USA							
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: African American	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Shoe Salesman		16b. Kind of Business/Industry Zimmerman Shoe Store	
17. Father's Name (First, Middle, Last) Harry L. Johnson Sr.				18. Mother's Name (First, Middle, Maiden Surname) Edna Mae Cromwell			
19a. Informant's Name/Relationship (Type, Print) Mrs. Edith Redmond (Sister)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6810 Parsons Ave. Balto. Md. 21207			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest		20c. Location - City or Town, State 7/15/97 Owings Mills, Md.			
21. Signature of Funeral Service Licensee Joseph L. Russ				22. Name and Address of Facility Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pulmonary Tuberculosis Due to (or as a consequence of): b. Acquired Immune Deficiency Syndrome Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier Laguina				29c. License number 89291		29d. Date signed (Month, Day, Year) 7/7/97	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ma Lourdes Cecilia Guma, M.D. c/o Maryland General Hospital							
31. Date filed (Month, Day, Year) JUL 14 1997				32. Registrar's Signature John Davidson-Randall			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21188

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>John Jackson</i>				2. Date of Death Month <i>July</i> Day <i>9</i> Year <i>1997</i>		3. Time of Death <i>9:10 AM</i>	
	4a. Facility Name (If not institution, give street and number) <i>Sinai Hospital, 2401 W. Belvedere Ave</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>(Baltimore City)</i>	
Funeral Director	5. Social Security Number <i>220-05-7611</i>	6. Sex <i>1</i> M <i>2</i> F	7. Age (In yrs. last birthday) <i>86</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>Sept. 20, 1910</i>		9. Birthplace (State or Foreign Country) <i>Virginia</i>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <i>Maryland</i>	10b. County <i>N/A</i>	10c. City, Town or Location <i>Baltimore</i>			10d. Inside City Limits <i>1</i> Yes <i>2</i> No		
	10e. Street and Number <i>3616 Fairview Ave.</i>			10f. Zip Code <i>21216</i>		10g. Citizen of What Country? <i>USA</i>		
	11. Marital Status <i>3</i> Widowed <i>2</i> Married <i>1</i> Never Married		12. Was Decedent Ever In U.S. Armed Forces? <i>1</i> Yes <i>2</i> No		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <i>1</i> Yes <i>2</i> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10</i> College (1-4 or 5+) <i>0</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Unemployed</i>		16b. Kind of Business/Industry <i>Never worked</i>			
	17. Father's Name (First, Middle, Last) <i>unknown</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>unknown</i>			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) (Care provider) <i>Mrs. Augustine Butler</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3616 Fairview Ave. Balto, Md. 21216</i>			
	20a. Method of Disposition <i>1</i> Burial <i>2</i> <input checked="" type="checkbox"/> Cremation <i>3</i> Removal from State <i>4</i> Donation <i>5</i> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Greenmount</i>		20c. Location - City or Town, State <i>7/15/97 Balto. Md.</i>			
	21. Signature of Funeral Service Licensee <i>Joseph L. Russ</i>				22. Name and Address of Facility <i>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</i>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>Pneumonia secondary to Staph. Aureus</i> Due to (or as a consequence of): b. <i>Bacteremia</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
	Approximate Interval Between Onset and Death e. <i>8 days</i> b. <i>8 days</i>							
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>cerebrovascular accident, sacral decubitus ulcer, poor nutritional status</i>						23b. Did tobacco use contribute to the cause of death? <i>1</i> Yes <i>2</i> <input checked="" type="checkbox"/> No <i>3</i> Probably <i>4</i> Unknown	
							24a. Was an autopsy performed? <i>1</i> Yes <i>2</i> <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <i>1</i> Yes <i>2</i> No	
	25. Was case referred to medical examiner? <i>1</i> Yes <i>2</i> <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <i>1</i> Inpatient <i>2</i> ER/Outpatient <i>3</i> DOA Other: <i>4</i> Nursing Home <i>5</i> Residence <i>6</i> Other (Specify)					
	27. Manner of Death <i>1</i> <input checked="" type="checkbox"/> Natural <i>2</i> Accident <i>3</i> Suicide <i>4</i> Homicide <i>5</i> Pending investigation <i>6</i> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <i>1</i> Yes <i>2</i> No	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
29a. Certifier (Check only one) <i>1</i> <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <i>2</i> <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Anna Abraham MD</i>		29c. License number <i>AS2402321-449516</i>		29d. Date signed (Month, Day, Year) <i>July 9, 1997</i>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>Anna Abraham, MD Sinai Hospital, 2401 W. Belvedere Ave. Baltimore, MD 21215</i>								
31. Date filed (Month, Day, Year) <i>JUL 14 1997</i>				32. Registrar's Signature <i>Julia Davidson-Ross</i>				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21189

Items 28a-28f 7-14-97 FilmG749 W.H. Per Doctor

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EDWARD JACKSON			2. Date of Death Month 6 Day 2 Year 97		3. Time of Death 9:20	
	4a. Facility Name (If not institution, give street and number) UNIVERSITY OF MARYLAND HOSPITAL			4b. City, Town, or Location of Death BALTIMORE		4c. County of Death	
Funeral Director	5. Social Security Number 214 44 2048		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 61 Yrs.		8. Date of Birth (Month, Day, Year) 8 31 35
	9. Birthplace (State or Foreign Country) unknown						
To Be Completed by Funeral Director	Usual Residence of Decedent						
	10a. State unknown		10b. County unknown		10c. City, Town or Location unknown		10d. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number unknown			10f. Zip Code unknown		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) unknown			16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unknown		16b. Kind of Business/Industry unknown	
	17. Father's Name (First, Middle, Last) unknown			18. Mother's Name (First, Middle, Maiden Surname) Othelia Turner			
	19a. Informant's Name/Relationship (Type, Print) Corine Hack/aunt			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5318 Beauford Street, Baltimore, Maryland			
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in state		20b. Place of Disposition (Name of cemetery, crematory or other place) in state		Date		20c. Location - City or Town, State
	21. Signature of Funeral Service Licensee Ronald S. Wade, Director			22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiorespiratory failure due to MI Due to (or as a consequence of): b. congestive failure Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hepatocellular CA (terminal) ESRD 20 to HTN						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hepatocellular CA (terminal) ESRD 20 to HTN							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 10/1/97		28b. Time of Injury 1:15 M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred MI		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Acute Myocardial Infarction		28f. Location (Street and Number or Rural Route Number, City or Town, State) 22 S. Green Street, UMMS			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier Dr. Otega, MD			29c. License number D0050742		29d. Date signed (Month, Day, Year) 6-2-97		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Luis M. ORTEGA UMMS Division of Nephrology							
31. Date filed (Month, Day, Year) JUL 14 1997		32. Registrar's Signature Davidson Randall					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21190

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ARLINE B. KIDD				2. Date of Death Month Day Year July 8 1997		3. Time of Death 11:25A	
	4e. Facility Name (If not institution, give street and number) Mercy Stella Maris-Hospice				4b. City, Town, or Location of Death Baltimore		4c. County of Death NA	
Funeral Director	5. Social Security Number 216-05-0221		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) 06-01-11	
	9. Birthplace (State or Foreign Country) VA		10a. State Md		10b. County NA		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 501 East Preston Street Apt 526		10f. Zip Code 21202	
	10g. Citizen of What Country? USA				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th Grade College (1-4 or 5+) NA	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic				16b. Kind of Business/Industry various trades		17. Father's Name (First, Middle, Last) Augustus Sessoms	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) Rebecca Roberts				19. Informant's Name/Relationship (Type, Print) Margaret Moore		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3816 Hill Street Loris, SC 29569	
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Mem. Pk. Cem.		20c. Location - City or Town, State 07-12-97 Arbutus, Md.	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Vanessa Cook				22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.MArch FH 1101 E. North Avenue			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC LUNG CANCER Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death ~ 8 mos			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) STELLA MARIS AT MERCY Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) HOSPICE			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how Injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Dr. J. J. J. J.			
	29c. License number D40480				29d. Date signed (Month, Day, Year) July 9, 1997			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FERNANDO J. PEREZ, MD 5810 BELAIR RD. BALTO., MD 21206				31. Date filed (Month, Day, Year) JUL 14 1997			
	32. Registrar's Signature John Davidson-Randall				33. Date of Death (Month, Day, Year) JUL 8 1997			

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

97-3823-510

ELEANOR

KOLLER

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State of Maryland / Department of Health and Mental Hygiene

97 21191

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Eleanor A. Koller				2. Date of Death Month JULY Day 11 Year 1997		3. Time of Death 2:09 P.M.	
	4e. Facility Name (If not institution, give street and number) GOOD SAMARITAN HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death	
Funeral Director	5. Social Security Number 213-26-2611		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) August 20, 1928	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street end Number 6527 Hilltop Avenue				10f. Zip Code 21206		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Registered Nurse		16b. Kind of Business/Industry Health Care		
17. Father's Name (First, Middle, Last) Paul W. Sick				18. Mother's Name (First, Middle, Maiden Surname) Elsie Sophia Schuette				
19a. Informant's Name/Relationship (Type, Print) Mrs. Pamela Savoie / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 Sandhill Road Baltimore, MD 21221				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery		Date 7/15/97		20c. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee Timothy S. Harman				22. Name and Address of Facility Leonard J. Ruck, Inc. Funeral Home 5305 Harford Road Baltimore, MD 21214				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? INSPECTION <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier [Signature]						
		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JULY 12, 1997				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) JUL 14 1997		32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

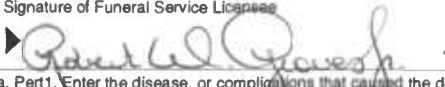

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21192

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ELLEN KRADICK				2. Date of Death Month JULY 10 , Day 10 , Year 1997		3. Time of Death 11:05 AM																												
	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore																												
Funeral Director	5. Social Security Number 076-18-4143	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 4, 1924	9. Birthplace (State or Foreign Country) ITALY																												
	Usual Residence of Decedent																																		
To Be Completed by Funeral Director	10a. State MD.	10b. County BALTIMORE	10c. City, Town or Location COCKEYSVILLE			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																													
	10e. Street and Number 604 KNOLLCREST DRIVE			10f. Zip Code 21030		10g. Citizen of What Country? USA																													
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE																												
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE		16b. Kind of Business/Industry Home																														
	17. Father's Name (First, Middle, Last) CARMINE D'Addario			18. Mother's Name (First, Middle, Maiden Surname) Gemma Battaglia																															
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Ronald D'Addario /nephew			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 303 Limestone Valley DR #D, Cockeysville Md 21030																															
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fr. Lincoln Cemetery		Date July 14 1997	20c. Location - City or Town, State Bladensburg, Md.																													
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Evans Chapel of Chimes 2325 York Rd Timonium Md																															
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																		
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td colspan="6">RESPIRATORY FAILURE</td> <td>Approximate Interval Between Onset and Death MINUTES</td> </tr> <tr> <td colspan="6">e. Due to (or as a consequence of): CARDIOGENIC SHOCK</td> <td>DAYS</td> </tr> <tr> <td colspan="6">b. Due to (or as a consequence of): ACUTE MYOCARDIAL INFARCTION</td> <td>DAYS</td> </tr> <tr> <td colspan="6">c. Due to (or as a consequence of): CORONARY ARTERY DISEASE</td> <td>YEARS</td> </tr> </table>							Immediate Cause (Final disease or condition resulting in death)	RESPIRATORY FAILURE						Approximate Interval Between Onset and Death MINUTES	e. Due to (or as a consequence of): CARDIOGENIC SHOCK						DAYS	b. Due to (or as a consequence of): ACUTE MYOCARDIAL INFARCTION						DAYS	c. Due to (or as a consequence of): CORONARY ARTERY DISEASE					
Immediate Cause (Final disease or condition resulting in death)	RESPIRATORY FAILURE						Approximate Interval Between Onset and Death MINUTES																												
	e. Due to (or as a consequence of): CARDIOGENIC SHOCK						DAYS																												
	b. Due to (or as a consequence of): ACUTE MYOCARDIAL INFARCTION						DAYS																												
	c. Due to (or as a consequence of): CORONARY ARTERY DISEASE						YEARS																												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PERIPHERAL VASCULAR DISEASE DIABETES						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																													
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																													
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																																	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																													
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred																															
28f. Location (Street and Number or Rural Route Number, City or Town, State)																																			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																																			
29b. Signature and title of certifier  Richard L. Linthicum M.D.				29c. License number 31826		29d. Date signed (Month, Day, Year) 7-10-97																													
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD L. LINTHICUM, M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204																																			
31. Date filed (Month, Day, Year) JUL 14 1997				32. Registrar's Signature 																															

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Reg. No.

97 21193

1. Decedent's Name (First, Middle, Last)
JOSEPH JOHN LINK, JR.
2. Date of Death
Month Day Year
July 11, 1997
3. Time of Death
12:45 AM
4a. Facility Name (If not institution, give street and number)
GREATER BALTIMORE MEDICAL CENTER
4b. City, Town, or Location of Death
TOWSON
4c. County of Death
BALTIMORE COUNTY
5. Social Security Number
168-05-8557
6. Sex
1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday)
48 Yrs.
8. Date of Birth (Month, Day, Year)
Nov 24, 1918
9. Birthplace (State or Foreign Country)
Pennsylvania
10a. State
Maryland
10b. County
N/A
10c. City, Town or Location
Baltimore City
10d. Inside City Limits
1 ☒ Yes 2 ☐ No
10e. Street and Number
5012 Greenleaf Road
10f. Zip Code
21210
10g. Citizen of What Country?
USA
11. Marital Status
1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc.
Specify: White
15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) Collegia (1-4 or 5+)
4 yrs
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Metallurgical Engineer
16b. Kind of Business/Industry
Steel Production
17. Father's Name (First, Middle, Last)
Joseph John Link, Sr.
18. Mother's Name (First, Middle, Maiden Summa)
Orpha McNeal
19a. Informant's Name/Relationship (Type, Print)
Katherine Griffin Link (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5012 Greenleaf Road, Baltimore, Maryland 21210
20a. Method of Disposition
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Mem. Grdns 7/14/97 Timonium, Maryland
20c. Location - City or Town, State
21. Signature of Funeral Service Licensee
Martin D. Lawson
22. Name and Address of Facility
Mitchell-Wiedefeld Home
6500 York Road, Baltimore, Maryland 21212
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediata Cause (Final disease or condition resulting in death)
a. CEREBROVASCULAR ACCIDENT
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Approximate Interval Between Onset and Death
4 days
23b. Did tobacco use contribute to the cause of death?
1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension
25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one)
Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. Manner of Death
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
M
28c. Injury at Work?
1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one)
1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
29b. Signature and title of certifier
29c. License number
D33400
29d. Date signed (Month, Day, Year)
7/11/97
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Iredell W. Iglehart, III, M.D., 500 W. University Pkwy., Baltimore, MD 21218
31. Date filed (Month, Day, Year)
JUL 14 1997
32. Registrar's Signature
Julia Anderson-Randall

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 21194**
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <div style="text-align: center; font-size: 1.2em;">Carolyn Lyons</div>				2. Date of Death Month <u>July</u> Day <u>10</u> Year <u>97</u>		3. Time of Death <u>11:26pm</u>	
	4a. Facility Name (If not institution, give street and number) <div style="text-align: center;">Good Samaritan Nursing Center</div>				4b. City, Town, or Location of Death <div style="text-align: center;">Baltimore</div>		4c. County of Death <div style="text-align: center;">N/A</div>	
Funeral Director	5. Social Security Number <u>216-28-8413</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>88</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>Jan 24, 1909</u>	
	9. Birthplace (State or Foreign Country) <u>Baltimore, MD</u>		10a. State <u>MD</u>		10b. County <u>N/A</u>		10c. City, Town or Location <u>Baltimore</u>	
Usual Residence of Decedent								
10a. State <u>MD</u>			10b. County <u>N/A</u>			10c. City, Town or Location <u>Baltimore</u>		
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			10e. Street and Number <u>1307 West old Cold Spring Lane</u>			10f. Zip Code <u>21209</u>		
10g. Citizen of What Country? <u>U.S.A.</u>			11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <u>XXX</u>		
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <u>White</u>			14. Race - American Indian, Black, White, etc. Specify: <u>White</u>			15. Decedent's Education (Specify only highest grade completed) <u>12th</u>		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Collection at Probation Dept. State of Maryland</u>			16b. Kind of Business/Industry			17. Father's Name (First, Middle, Last) <u>Adelbert Plantholt</u>		
18. Mother's Name (First, Middle, Maiden Surname) <u>Catherine Popp</u>			19a. Informant's Name/Relationship (Type, Print) <u>Jack Lyons (Son)</u>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1913 Burnwood Rd. Balto, MD 21239</u>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <u>New Cathedral Cemetery</u>			20c. Location - City or Town, State <u>Balto, MD</u>		
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <u>Burgee-Henss Funeral Home 3631 Falls Rd Balto, MD 21211</u>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <u>Metastatic Non Small Cell Carcinoma</u></p> <p>Due to (or as a consequence of):</p> <p>b. _____</p> <p>Due to (or as a consequence of):</p> <p>c. _____</p> <p>Due to (or as a consequence of):</p> <p>d. _____</p> </div> <div style="width: 35%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p><u>2 month</u></p> </div> </div>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)			28b. Time of Injury <u>M</u>		
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			28d. Describe how injury occurred			28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 			29c. License number <u>D20396</u>			29d. Date signed (Month, Day, Year) <u>July 11, 1997</u>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Dr. Hahn Good Samaritan Nursing 1601 E. Belvedere 21239</u>								
31. Date filed (Month, Day, Year) <u>JUL 14 1997</u>								

Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

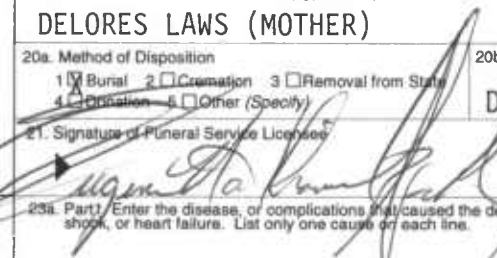

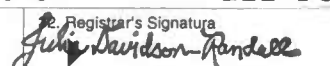
EARL

State of Maryland / Department of Health and Mental Hygiene

97 21-195

LAWS Items: 23a part I, 27, 28a-f per MEO G-749 7/18/97 dh Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EARL LAWS		2. Date of Death Month: JULY Day: 4 Year: 1997		3. Time of Death 7:13 P.M.
	4a. Facility Name (If not institution, give street and number) 2543 MCHENRY STREET		4b. City, Town, or Location of Death BALTO. CITY		4c. County of Death N/A
Funeral Director	5. Social Security Number 214-80-8752	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 30 Yrs.	If Under 1 Year Months: Days:	8. Date of Birth (Month, Day, Year) 8-11-1966
	9. Birthplace (State or Foreign Country) MD				
Usual Residence of Decedent					
10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 2508 W. PRATT STREET			10f. Zip Code 21223		10g. Citizen of What Country? U.S.A.
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: AFR.AMERICAN					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+):		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PAINTER		16b. Kind of Business/Industry PAINTING CO.	
17. Father's Name (First, Middle, Last) THOMAS KENNEDY			18. Mother's Name (First, Middle, Maiden Surname) DELORES LAWS		
19a. Informant's Name/Relationship (Type, Print) DELORES LAWS (MOTHER)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2508 W. PRATT STREET BALTO. MD 21223		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Other (Specify):		20b. Place of Disposition (Name of cemetery, crematory or other place) DULANEY VALLEY CEM.		20c. Location - City or Town, State 7/10/1997 DULANEY VALLEY MD	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTO. MD 21217			
23a. Part I. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. NARCOTIC AND COCAINE INTOXICATION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify):					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) found 7/4/97		28b. Time of Injury found 7:09M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred unknown			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) found at a friend's house		28f. Location (Street and Number or Rural Route Number, City or Town, State) 2543 McHenry Street Baltimore, Maryland			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JULY 5, 1997	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) JUL 14 1997		32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitBaltimore, Maryland 21215-0820
permit. Pages 1 and 2 should be retained 24 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "Natural" or "Items 23a or 23a-f show any injury or other traumatic event," a medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21196

Item 24a 7-14-97 Film G749 W.H. Per Doctor

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RUFUS LIGGON				2. Date of Death Month Day Year April 17, 1997				3. Time of Death 2:30 PM		
	4a. Facility Name (If not institution, give street and number) Delaney Towson Nursing Home				4b. City, Town, or Location of Death Towson				4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 160-18-0349		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) June 6, 1912		9. Birthplace (State or Foreign Country) unknown		
	Usual Residence of Decedent 10a. State Maryland				10b. County Baltimore		10c. City, Town or Location Towson		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 111 West Road				10f. Zip Code 21204				10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) unknown				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unknown				18b. Kind of Business/Industry unknown			
17. Father's Name (First, Middle, Last) unknown						18. Mother's Name (First, Middle, Maiden Surname) unknown					
19a. Informant's Name/Relationship (Type, Print) unknown						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unknown					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) in state				20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State			
21. Signature of Funeral Service Licensee Ronald S. Wade, Director						22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201					
23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
Immediate Cause (Final disease or condition resulting in death) e. Aspiration pneumonia Due to (or as a consequence of): b. Exacerbation obstructive Airway Disease Due to (or as a consequence of): c. Dementia Due to (or as a consequence of): d.											
23a. Part 2. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. S/p g tube feeding						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Silvia Shih				29c. License number D50600		29d. Date signed (Month, Day, Year) 5/16/1997	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) SILVIA SHIH 301 ST. PAUL PL., BOB 403 BALTIMORE MD 21202											
31. Date filed (Month, Day, Year) JUL 14 1997				32. Registrar's Signature Julia Davidson-Randall							

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)
EDDIE MCFATTEN

2. Date of Death
Month Day Year
JULY 02, 1997

3. Time of Death
4:47 PM.

Funeral
Director

4a. Facility Name (If not institution, give street and number)
501 E. PRESTON ST. APT. # 313

4b. City, Town, or Location of Death
BALTIMORE

4c. County of Death
N/A

5. Social Security Number
259-46-0374

6. Sex
☒ M ☐ F

7. Age (In yrs. last birthday)
43 Yrs.

8. Date of Birth (Month, Day, Year)
MAY 13, 1934

9. Birthplace (State or Foreign Country)
GA

Usual Residence of Decedent

10a. State
MD

10b. County
N/A

10c. City, Town or Location
BALTO

10d. Inside City Limits
☒ Yes ☐ No

10e. Street and Number
501 E. PRESTON ST APT 313

10f. Zip Code
21202

10g. Citizen of What Country?
U.S.A.

11. Marital Status
☐ Never Married ☐ Married
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?
☒ Yes ☐ No 1953-1956

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.
Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
12th N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
UNEMPLOYED

16b. Kind of Business/Industry
N/A

17. Father's Name (First, Middle, Last)
UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname)
UNKNOWN

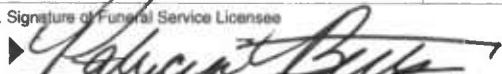
19a. Informant's Name/Relationship (Type, Print)
PATRICIA MCFATTEN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
810 WEBB CT BALTO, MD 21202

20a. Method of Disposition
☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)
GARRISON FOREST VA CEM 1997

20c. Location - City or Town, State
JULY 11 OWINGS MILLS, MD

21. Signature of Funeral Service Licensee


22. Name and Address of Facility
BETTS FUNERAL HOME
1129 N. CAROLINE ST BALTO MD 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hypertensive Atherosclerotic Cardiovascular Disease
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?
1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury
M

28c. Injury at Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier


29c. License number
O.C.M.E.

29d. Date signed (Month, Day, Year)
JULY 03, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)
JUL 14 1997

32. Registrar's Signature


State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21198

ANGELICA M. MEJIA

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANGELICA M. MEJIA				2. Date of Death Month Day Year July 10, 1997				3. Time of Death 12:20 PM	
	4a. Facility Name (If not institution, give street and number) ROUTE#95 SOUTH				4b. City, Town, or Location of Death RIVERSIDE				4c. County of Death HARFORD	
Funeral Director	5. Social Security Number UNK	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 32 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 03/26/65		9. Birthplace (State or Foreign Country) Mexico		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State NY	10b. County Queens	10c. City, Town or Location Mexico City				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 47-11 160th Street				10f. Zip Code		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: Mexican			14. Race - American Indian, Black, White, etc. Specify: Mexican		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accountant			16b. Kind of Business/Industry unk		
	17. Father's Name (First, Middle, Last) Florescia Mejia				18. Mother's Name (First, Middle, Maiden Surname) Estela Osorio					
	19a. Informant's Name/Relationship (Type, Print) Florescio M. Mejia - Father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Post Street, Yonkers, NY 10705					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cementerio Municipal		20c. Location - City or Town, State 07/17/97 Mexico					
	21. Signature of Funeral Service Licensee [Signature]				22. Name and Address of Facility Unity Funeral Home, Inc., 108 W. North Avenue Baltimore, MD 21201 - (410) 752-4941					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) ROADWAY										
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined										
28a. Date of Injury (Month, Day, Year) 7-10-97										
28b. Time of Injury 1115 M										
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
28d. Describe how Injury occurred Passenger in auto accident										
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) HIGHWAY										
28f. Location (Street and Number or Rural Route Number, City or Town, State) I-955										
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier [Signature] O.C.M.E.										
29c. License number O.C.M.E.										
29d. Date signed (Month, Day, Year) JULY 11, 1997										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Allen Locke, MD 111 Penn Street, Baltimore, Maryland 21201										
31. Date filed (Month, Day, Year) JUL 14 1997										
32. Registrar's Signature [Signature]										

Baltimore, Maryland 21215-0029

Division of Vital Records, P.O. Box 68760,

State Registrar

B.K.S

UNK.97-152

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21199

ITEM: 6,16a,b,19b per FH G -749 7-31-97 eoh
FLORENCIO A. MEJIA

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FLORENCIO A. MEJIA				2. Date of Death Month JULY Day 10, Year 1997		3. Time of Death 1220PM	
	4a. Facility Name (If not institution, give street and number) ROUTE# 95 SOUTH				4b. City, Town, or Location of Death RIVERSIDE		4c. County of Death HARFORD	
Funeral Director	5. Social Security Number 126-62-8623	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 37 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 02/14/60		9. Birthplace (State or Foreign Country) Mexico
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State NY	10b. County Queens		10c. City, Town or Location Flushing			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 47-11 160th Street				10f. Zip Code		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: Mexican		14. Race - American Indian, Black, White, etc. Specify: Hispanic	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH Grade College (1-4or 5+) 2			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) STORE OWNER Housewife		16b. Kind of Business/Industry BUSINESSMAN Domestic		
	17. Father's Name (First, Middle, Last) Florencio Mejia				18. Mother's Name (First, Middle, Maiden Surname) Estela Osorio			
	19a. Informant's Name/Relationship (Type, Print) Florencio M. Mejia - Father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 47-11 160th ST FLUSHING NY 11358 1 Post Street, Yonkers, NY 10705			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maple Grave Cemetery		20c. Location - City or Town, State Queens, NY		20d. Date 07/17/97	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Unity Funeral Home, Inc., 108 W. North Avenue Baltimore, MD 21201 - (410) 752-4941			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Head Injury</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) ROADWAY				
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 7-10-97		28b. Time of Injury 1115 M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred Passenger in auto accident
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) HAWAII				28f. Location (Street and Number or Rural Route Number, City or Town, State) I-95S				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) JULY 11, 1997		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) JASON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) JUL 14 1997				32. Registrar's Signature <i>[Signature]</i>				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21200

Item 1 7-14-97 Film G749 W.H.Per DOCTOR

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ARON MILLER AKA MARION				2. Date of Death Month 07 Day 3 Year 97		3. Time of Death 2:30 pm	
	4a. Facility Name (If not institution, give street and number) LAUREL REGIONAL HOSPITAL				4b. City, Town, or Location of Death LAUREL		4c. County of Death N/A	
Funeral Director	5. Social Security Number 216-86-7200		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 27 Yrs.		8. Date of Birth (Month, Day, Year) JUNE 16, 1970	
	10a. State MD		10b. County N/A		10c. City, Town or Location BALTO		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 1104 E. HOFFMAN ST				10f. Zip Code 21202		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+) N/A				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) UNEMPLOYED		16b. Kind of Business/Industry N/A		
17. Father's Name (First, Middle, Last) WILLIE JAMES				18. Mother's Name (First, Middle, Maiden Surname) DARLENE MILLER				
19a. Informant's Name/Relationship (Type, Print) DARLENE MILLER/MOTHER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1104 E. Hoffman ST BALTO, MD 21202				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEM		20c. Location - City or Town, State BALTO, MD		20d. Date JULY 10 1997	
21. Signature of Funeral Service Licensee <i>Patricia Betts</i>				22. Name and Address of Facility BETTS FUNERAL HOME 1129 N. CAROLINE ST BALTO, MD 21213				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. KAPOSI'S SARCOMA OF THE LUNG Due to (or as a consequence of): ACQUIRED IMMUNODEFICIENCY SYNDROME Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Patricia Betts</i>				29c. License number D42804		29d. Date signed (Month, Day, Year) 7/13/97		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sabel Geta Chew 7300 Van Dusen Rd Laurel, MD 20707								
31. Date filed (Month, Day, Year) JUL 14 1997				32. Registrar's Signature <i>John Davidson-Randall</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural" or item 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21201

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JULIA

MASKELL

2. Date of Death

Month
JULYDay
10Year
1997

3. Time of Death

12:10pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

214-01-5818

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

January 22, 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6641 Walther Avenue Apt. F

10f. Zip Code

21206

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

George

Noll

18. Mother's Name (First, Middle, Maiden Surname)

Katherina

Keiffer

19a. Informant's Name/Relationship (Type, Print)

Mr. Gerald F. Maskell/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6641 Walther Avenue Apt. F Baltimore, Maryland 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Moreland Memorial Park

Date

7/14/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Brian A. Willem

22. Name and Address of Facility

Leonard J. Ruck Funeral Home, Inc.
5305 Harford Road Baltimore, Maryland 2121423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Acute Pulmonary Embolus

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 hr.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Lymphocytic Leukemia
with Splenic Infarct + Hematoma

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

Inpatient

2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Brian A. Willem

29c. License number

020396

29d. Date signed (Month, Day, Year)

July 10, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVIS HAHN, MD 5601 LOCH RAVEN BLVD., MD 21239-2925

31. Date filed (Month, Day, Year)

JUL 14 1997

32. Registrar's Signature

Julia Anderson-Randall

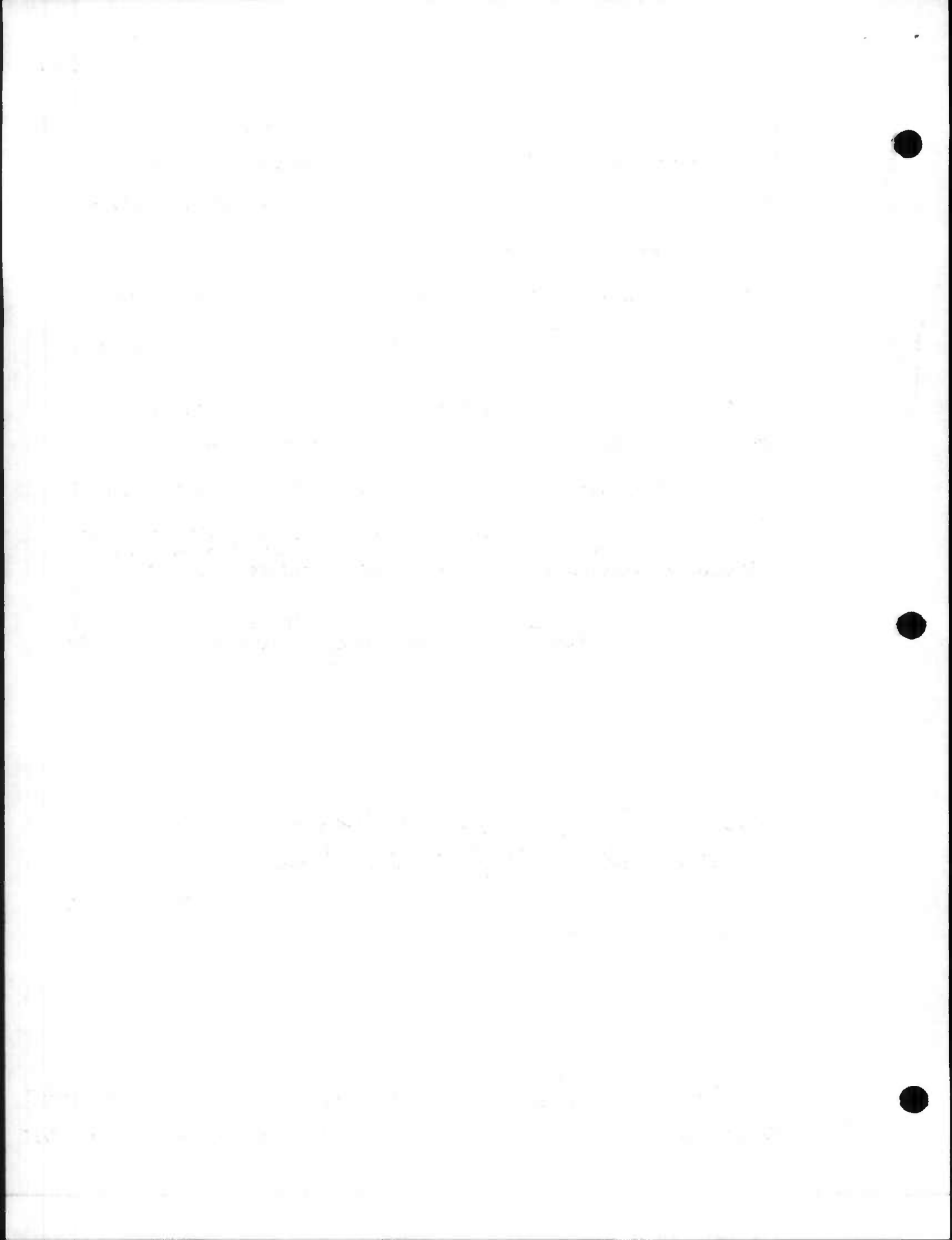
State
RegistrarBaltimore, Maryland 21215-0620
permit. Pages 1 and 2 should be filed within 48 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", options 23a or 23a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



WRC
97-3749-510
CARLTON
MCNEIL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21202

Items: 23a part I, 27, 28a-f per MEO G-750 8/6/97 dh Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) CARLTON L. MCNEIL				2. Date of Death Month Day Year JULY 08, 1997		3. Time of Death 4:46 AM.			
4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS HOSPITAL BAYVIEW				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A			
5. Social Security Number 213-70-4358		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 35 Yrs.		8. Date of Birth (Month, Day, Year) July 26, 1961			
9. Birthplace (State or Foreign Country) MARYLAND		10a. State MD.		10b. County N/A		10c. City, Town or Location BALTIMORE			
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 3201 E. LOMBARD STREET		10f. Zip Code 21224		10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CARPENTER		16b. Kind of Business/Industry LOCAL 516					
17. Father's Name (First, Middle, Last) JAMES LOUIS MCNEIL				18. Mother's Name (First, Middle, Maiden Surname) SHIRLEY MAE WOOSLEY					
19a. Informant's Name/Relationship (Type, Print) REGINA CHAVIS/FIANCE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3201 E. LOMBARD STREET, BALTIMORE, MD. 21224					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) PARKWOOD CEMETERY		20c. Location - City or Town, State BALTIMORE, MD.		20d. Date 7/11/1997			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility LILLY & ZEILER INC. 1901 EASTERN AVENUE/21231					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. ALCOHOL AND COMBINED DRUG INTOXICATION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) found 7/8/97		28b. Time of Injury found 4:20M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
		28d. Describe how injury occurred unknown		28e. Location (Street and Number or Rural Route Number, City or Town, State) 3201 E. Lombard Street, Baltimore, Maryland		28f. Location (Street and Number or Rural Route Number, City or Town, State) 3201 E. Lombard Street, Baltimore, Maryland			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JULY 08, 1997			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) JUL 14 1997 Registrar's Signature 									

Baltimore, Maryland 21201-0020
permit. Pages 1 and 2 should be filed with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than natural, or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

6

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21203

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM MILLER			2. Date of Death Month JULY Day 11 Year 1997			3. Time of Death 10:28A			
	4a. Facility Name (If not institution, give street and number) Liberty Medical Center			4b. City, Town, or Location of Death Baltimore			4c. County of Death City			
Funeral Director	5. Social Security Number 309-16-0723		6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 1, 1921		9. Birthplace (State or Foreign Country) Minnesota	
	Usual Residence of Decedent									
10a. State Maryland			10b. County City		10c. City, Town or Location Baltimore			10d. Inside City Limits 1 Yes 2 No		
10e. Street and Number 4004 Fords Lane Apt. 1B					10f. Zip Code 21215		10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Custodian			16b. Kind of Business/Industry Baltimore Hebrew		
17. Father's Name (First, Middle, Last) Homer H. Miller					18. Mother's Name (First, Middle, Maiden Surname) Bessie L. Pearson					
19a. Informant's Name/Relationship (Type, Print) Jewel Miller - wife					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4004 Fords Lane Apt. 1B, Baltimore, Md. 21215					
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory			Date July 14, 1997		20c. Location - City or Town, State Baltimore, Md.		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Eckhardt Funeral Chapel 11605 Reisterstown Rd. Owings Mills, Md. 21117					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediata Cause (Final disease or condition resulting in death) a. SEPSIS Due to (or as a consequence of): b. ISCHEMIC GANGRENE RT. FOOT. Due to (or as a consequence of): c. CARDIAC ARRHYTHMIA Due to (or as a consequence of): d. CORONARY ARTERY DISEASE									Approximate Interval Between Onset and Death 1 DAY unknown 1 DAY unknown	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. - DIABETES MELLITUS - HYPERTENSION - SIP CORONARY ARTERY BY-PASS GRAFT									23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown	
24a. Was an autopsy performed? 1 Yes 2 No			24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No							
25. Was case referred to medical examiner? 1 Yes 2 No			26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier  MD.			29c. License number D 23300		29d. Date signed (Month, Day, Year) JULY 11th 1997		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUDHIR D. PATEL 2600 Liberty Rd. BALTO. MD. 21215										
31. Date filed (Month, Day, Year) JUL 14 1997										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 48 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than natural, or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21204

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Benny Cleveland McGriff				2. Date of Death Month Day Year JULY 10, 1997		3. Time of Death 2211PM	
	4a. Facility Name (If not institution, give street and number) ST. JOSEPH HOSPITAL E.R.				4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE COUNTY	
Funeral Director	5. Social Security Number 248-90-2380		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 46 Yrs.		8. Date of Birth (Month, Day, Year) March 6, 1951	
	9. Birthplace (State or Foreign Country) South Carolina		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Cockeysville	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 1085 Misty Lynn Circle, apt J		10f. Zip Code 21030		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Financial Advisor		16b. Kind of Business/Industry Financial Planning			
	17. Father's Name (First, Middle, Last) Jack L. McGriff				18. Mother's Name (First, Middle, Maiden Surname) Esterlean Barnes			
	19a. Informant's Name/Relationship (Type, Print) Isabelle McGriff/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1085 Misty Lynn Circle, apt J, Cockeysville 21030			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Gardens		20c. Location - City or Town, State 7/17/97 Timonium, Maryland			
	21. Signature of Funeral Service Licensee Bryan W. Clary		22. Name and Address of Facility Lemmon Funeral Home 10 W. Padonia Road, Timonium, MD 21093					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
Physician /Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural/Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
Medical Certification: To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier [Signature]				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JULY 11, 1997	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. L. HEN LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201							
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	31. Date filed (Month, Day, Year) JUL 14 1997				32. Registrar's Signature [Signature]			
	33. Date of Death (Month, Day, Year) JULY 10, 1997							

AM
ALAN
NAGLE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 21205

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ALAN WILCOX NAGLE, JR.				2. Date of Death Month Day Year JULY 06, 1997		3. Time of Death 1:30 P		
	4a. Facility Name (If not institution, give street and number) 8307 LOCH RAVEN BLVD.				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 217-48-7235		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 56 Yrs.		8. Date of Birth (Month, Day, Year) June 5, 1941		
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MD.		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 8307 LOCH RAVEN BLVD.		10f. Zip Code 21286		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PRIEST		16b. Kind of Business/Industry RELIGIOUS		17. Father's Name (First, Middle, Last) ALAN W. NAGLE, SR.		18. Mother's Name (First, Middle, Maiden Surname) PHYLLIS IRENE HORNER		19a. Informant's Name/Relationship (Type, Print) REV. IAN DORNIC/FRIEND	
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2807 MOUNTAIN ROAD, JOPPA, MARYLAND 21085		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) WOODLAWN CEMETERY 7/10/1997		20c. Location - City or Town, State BALTIMORE, MD.		21. Signature of Funeral Service Licensee 	
22. Name and Address of Facility LILLY & ZEILER INC. 1901 EASTERN AVENUE 21231		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <u>Arteriosclerotic Cardiovascular Disease</u> Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
29b. Signature and title of certifier 		29c. License number OCME		29d. Date signed (Month, Day, Year) JULY 07, 1997		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) J. LARON WILCOX, MD 111 Penn Street, Baltimore, Maryland 21201		31. Date filed (Month, Day, Year) JUL 14 1997	
32. Registrar's Signature 									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than natural, for items 23a or 28a-f show any injury or other traumatic event, but the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

WRC
97-3748-510
JASON
OAKES

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

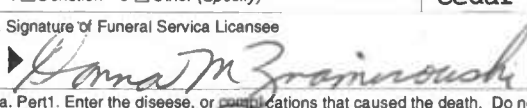
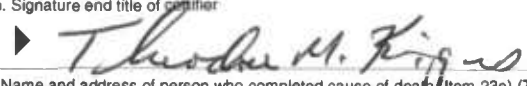
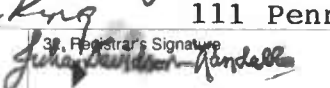
State of Maryland / Department of Health and Mental Hygiene

97 21206

Items: 23a part I, 27 per MEO G-750 8/6/97 dh

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jason Andrew Oakes				2. Date of Death Month JULY Day 08 Year 1997		3. Time of Death 3:40 AM.						
	4e. Facility Name (If not institution, give street and number) HARBOR HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A						
Funeral Director	5. Social Security Number 212 49 6963		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 9 Months 1 Days		8. Date of Birth (Month, Day, Year) Oct. 7, 1996		9. Birthplace (State or Foreign Country) Maryland				
	Usual Residence of Decedent												
10a. State Maryland			10b. County N/A			10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
10e. Street and Number 4130 Mariban Court					10f. Zip Code 21225		10g. Citizen of What Country? U.S.						
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) None College (1-4or 5+) N/A					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A			16b. Kind of Business/Industry N/A					
17. Father's Name (First, Middle, Last) Michael Andrew Oakes					18. Mother's Name (First, Middle, Maiden Surname) Tammy Lynn McLaughlin								
19a. Informant's Name/Relationship (Type, Print) Tammy McLaughlin / mother					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4130 Mariban Court Baltimore, Maryland 21225								
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery			Date 7/11/97		20c. Location - City or Town, State Baltimore, Maryland					
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. SUDDEN INFANT DEATH SYNDROME Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
										24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier 			29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JULY 08, 1997					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) THEODORE MCKINNEY 111 Penn Street, Baltimore, Maryland 21201													
31. Date filed (Month, Day, Year) JUL 14 1997			32. Registrar's Signature 										

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked "natural", or items 23a or 23a-1 show any injury or other traumatic cause, the Medical Examiner must be notified at 5052.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21207

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Charles Olevich

2. Date of Death

Month Day Year
July 10 1997

3. Time of Death

7:00 A.M.

4a. Facility Name (If not institution, give street and number)

805 Marigold Road

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

217 24 8988

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept. 29, 1930

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

805 Marigold Road

10f. Zip Code

21061

10g. Citizen of What Country?

U.S.

11. Marital Status

☐ Never Married ☐ Married
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☒ Yes ☐ No Korean
If Yes, Give
Year or Dates: Conflict13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Communication Specialist

16b. Kind of Business/Industry

C & P Telephone Co.

17. Father's Name (First, Middle, Last)

Algard Olevich

18. Mother's Name (First, Middle, Maiden Surname)

Alfredine DeVellers

19a. Informant's Name/Relationship (Type, Print)

Patricia Sweeney / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

805 Marigold Road Glen Burnie, Maryland 21061

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metro Crematory, Inc.

Date

7/11/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Gonce Funeral Home P.A.
4001 Ritchie Highway Baltimore, Md. 2122523a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Lung Carcinoma

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

6 months

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☒ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

26. Place of Death (Check only one)

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☐ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

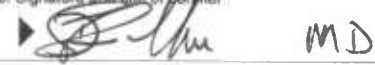
M

28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

 MD

29c. License number

D 38958

29d. Date signed (Month, Day, Year)

7/10/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Daljeet Singh Sidhu 1413 Annapolis Road #106, Odenton MD 21113

31. Date filed (Month, Day, Year)

JUL 14 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 23a is completed other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21208

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Sarah PRICE				2. Date of Death Month June Day 25 Year 1997		3. Time of Death 5:50p.m.	
	4a. Facility Name (If not institution, give street and number) Sinai Hospital of Baltimore				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 220-07-4032		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 3-7-06	9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State md.	10b. County N/A	10c. City, Town or Location BALTIMORE			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 2834 FAIRVIEW AVE.				10f. Zip Code 21216		10g. Citizen of What Country? U.S.A	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4or 5+) 		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOME MAKER		16b. Kind of Business/Industry DOMESTIC			
	17. Father's Name (First, Middle, Last) SAMUEL HALL				18. Mother's Name (First, Middle, Maiden Surname) (Last Name -) ELIZABETH (UNKNOWN)			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) FLORENCE HALL - NEICE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 314 E. LANVALE St Apt. 1st Balto. Md.			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) VOSCHELL CEMETERY 7101k BALTO. MD.		Date		20c. Location - City or Town, State	
	21. Signature of Funeral Service Licensee Jeff Miller				22. Name and Address of Facility 1639 N. Broadway Balto. Md 21213 JEFF MILLER P.C. FUNERAL HOME & SERVICE			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. UROSEPSIS Due to (or as a consequence of): b. URINARY TRACT INFECTION Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Severe Dehydration Non-Insulin dependent Diabetes mellitus						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Allen Rittlerman MD		29c. License number 027569		29d. Date signed (Month, Day, Year) 6/28/97		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Allen Rittlerman 1838 Grene Tree # 300								
31. Date filed (Month, Day, Year) JUL 14 1997								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21209

Item:8 per FH G-749 7/18/97 dh

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HARVEY PAGE, JR.

2. Date of Death

Month
JULYDay
11Year
1997

3. Time of Death

8:30 P.M.

4a. Facility Name (If not institution, give street and number)

JOSEPH

RITCHIE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

n/a

Funeral
Director

5. Social Security Number

215-05-6256

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

12/3
DEC. 4, 1918

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MDD

10b. County

n/a

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3915 CALLOWAY AVENUE apt. 512

10f. Zip Code

21215

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

BRICK WORKER

16b. Kind of Business/Industry

GENERAL REFRACTORY

17. Father's Name (First, Middle, Last)

HARVEY PAGE SR.

18. Mother's Name (First, Middle, Maiden Surname)

SUSIE BROOKS

19a. Informant's Name/Relationship (Type, Print)

SYLVIA TURNER- NIECE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3700 EGERTON ROAD, BALTIMORE, MD 21215

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST VA CEM. 7-15-97 OWINGS MILLS

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Shannon Stokes

22. Name and Address of Facility

WM. C. MARCH FH.-4300 WABASH AVENUE

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory arrest

Due to (or as a consequence of):

b. Prostate Cancer

Due to (or as a consequence of):

c. Metastatic to liver

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

5 min

9 mo

2 mo

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Hospice

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John W. Payne

29c. License number

D13012

29d. Date signed (Month, Day, Year)

12 July 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6565 N. Charles St.

Bkto. 21204

John W. Payne m.d.

31. Date filed (Month, Day, Year)

JUL 14 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21210

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Alease Potts				2. Date of Death Month July Day 05 Year 97		3. Time of Death 4:40am															
	4a. Facility Name (If not institution, give street and number) 2922 Parkwood Avenue				4b. City, Town, or Location of Death Baltimore		4c. County of Death NA															
Funeral Director	5. Social Security Number 218-60-7344		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 44 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 09-19-52	9. Birthplace (State or Foreign Country) Md.														
	Usual Residence of Decedent																					
10a. State Md.		10b. County NA		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No															
10e. Street and Number 2922 Parkwood Avenue				10f. Zip Code 21215		10g. Citizen of What Country? USA																
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black															
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th Grade College (1-4or 5+) NA				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer			16b. Kind of Business/Industry Unemployed															
17. Father's Name (First, Middle, Last) Andrew Corporal				18. Mother's Name (First, Middle, Maiden Surname) Lillie Auston																		
19a. Informant's Name/Relationship (Type, Print) Marilyn Porter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21229 113 N. Culver Street Baltimore, Maryland																		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Voshell Mem. Gardens			Date 07-12-97		20c. Location - City or Town, State Dundalk, Md.															
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue																		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																						
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>CERVICAL CANCER</td> <td>Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b.</td> <td>HIV Disease</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	CERVICAL CANCER	Due to (or as a consequence of):	Approximate Interval Between Onset and Death	b.	HIV Disease	Due to (or as a consequence of):	c.		Due to (or as a consequence of):	d.		Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	CERVICAL CANCER	Due to (or as a consequence of):	Approximate Interval Between Onset and Death																		
	b.	HIV Disease	Due to (or as a consequence of):																			
	c.		Due to (or as a consequence of):																			
	d.		Due to (or as a consequence of):																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown																
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred														
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																						
29b. Signature and title of certifier 		29c. License number 033215		29d. Date signed (Month, Day, Year) 07/10/97																		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHIRLEY THOMPSON-RICHARDS 100 WEST RD TOWSON MD. 21204																						
31. Date filed (Month, Day, Year) JUL 14 1997		32. Registrar's Signature 																				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

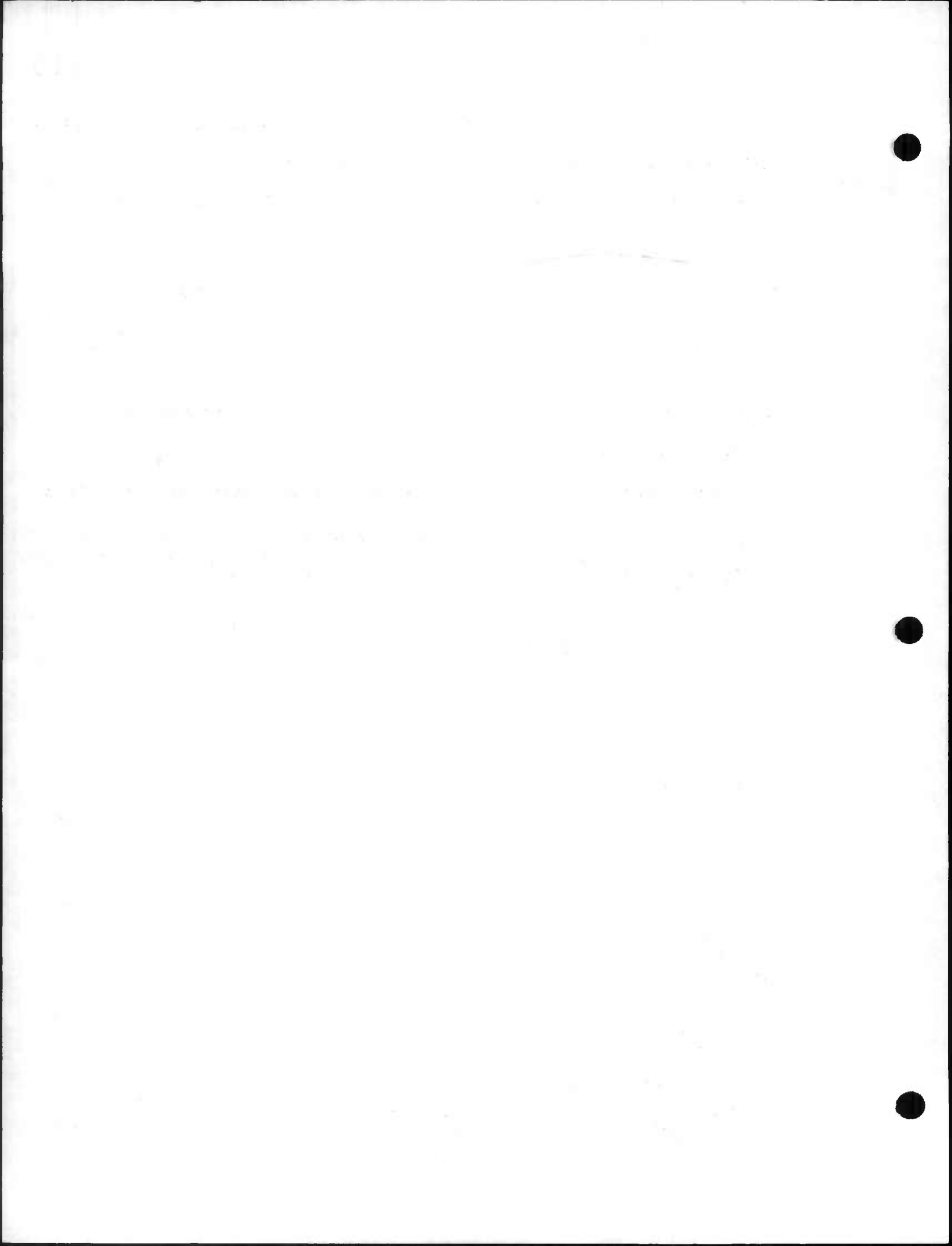
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEM: 12 per FH G-750 8-7-97 eom
PAUL P. DELLA-PENNA, JR.

State of Maryland / Department of Health and Mental Hygiene

97 21211

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Paul Peter Della Penna, Jr.				2. Date of Death Month JULY Day 09 Year 1997		3. Time of Death 5:25 PM	
	4a. Facility Name (If not institution, give street and number) 1400 BONSAI STREET				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 218-56-1420		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 46 Yrs.		8. Date of Birth (Month, Day, Year) April 7, 1951	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore City	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 1400 Bonsai Street		10f. Zip Code 21224	
	10g. Citizen of What Country? United States				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1951-87	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) 10 Years	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Route Salesman				16b. Kind of Business/Industry Food Industry		17. Father's Name (First, Middle, Last) Paul Peter Della Penna, Sr.	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) Rita Verna Wrzesinski				19a. Informant's Name/Relationship (Type, Print) Margaret A. Joyce/Ex Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 709 Hawkridge Drive Hamburg, PA 19526	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery		20c. Location - City or Town, State Baltimore, Maryland	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Johnny L. Ellis				22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Perforated Peptic (Duodenal) Ulcer Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atherosclerotic Cardiovascular Disease Hypertension				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) 7/14/1997			
To Be Completed by Physician/Medical Examiner	28b. Time of Injury M				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
To Be Completed by Physician/Medical Examiner	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
	29b. Signature and title of certifier Dennis J. Chute, MD				29c. License number O.C.M.E.			
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) JULY 10, 1997				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J Chute, MD 111 Penn Street, Baltimore, Maryland 21201			
	31. Date filed (Month, Day, Year) JUL 14 1997				32. Registrar's Signature Johnathan R. Randle			

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 23a or 23b is marked other than "natural", or items 23a or 23b show any injury or other unusual event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 21212

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ALONZO RAY SR				2. Date of Death Month Day Year JULY 09, 1997		3. Time of Death 2235PM	
	4e. Facility Name (If not institution, give street and number) UNIVERSITY HOSPITAL E.R.				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death N/A	
Funeral Director	5. Social Security Number 216-50-4917		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 49 Yrs.		8. Date of Birth (Month, Day, Year) JUNE 23, 1948	
	9. Birthplace (State or Foreign Country) NC		10a. State MD		10b. County N/A		10c. City, Town or Location BALTO	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 1312 N. KENWOOD AVE		10f. Zip Code 21213		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1967-1969		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MECHANIC		16b. Kind of Business/Industry AUTO SHOP			
	17. Father's Name (First, Middle, Last) JAMES RAY SR				18. Mother's Name (First, Middle, Maiden Surname) ANNA STUBBS			
	19a. Informant's Name/Relationship (Type, Print) LYNN DIXON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3531 ELMORA AVE BALTO, MD 21213			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GARRISON FOREST VA		20c. Location - City or Town, State OWINGS MILLS, MD		20d. Date JUL 15 1997	
	21. Signature of Funeral Service Licensee <i>Patricia Butts</i>		22. Name and Address of Facility BETTS FUNERAL HOME 1129 N. CAROLINE ST BALTO, MD 21213					
	23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Seizure Disorder</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
Physician /Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier <i>Dennis J. Chute</i>				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JULY 10, 1997	
State Registrar	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201							
	31. Date filed (Month, Day, Year) JUL 14 1997				32. Registrar's Signature <i>Don-Rendell</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" (item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21213

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DALLAS OLIN RENNER, SR.			2. Date of Death Month JULY Day 03 Year 1997		3. Time of Death 8:30 AM		
	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center			4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 213-05-8082		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 26, 1908	
	9. Birthplace (State or Foreign Country) Virginia		10a. State MD		10b. County Baltimore		10c. City, Town or Location White Hall	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 19641 Graystone Rd.		10f. Zip Code 21161		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machinist		16b. Kind of Business/Industry Manufacturing				
17. Father's Name (First, Middle, Last) James Renner			18. Mother's Name (First, Middle, Maiden Surname) Rosa Beatley					
19a. Informant's Name/Relationship (Type, Print) Dallas O. Renner, Jr./Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1201 Haven Wood Rd., Baltimore, MD 21218					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Prospect Hill Cemetery		20c. Location - City or Town, State Towson, MD		20d. Date July 7, 1997		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. RESPIRATORY INSUFFICIENCY PULMONARY EDEMA AND HEMORRHAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last THROMBOCYTOPENIA MYELODYSPLASIA								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 		29c. License number D 13140		29d. Date signed (Month, Day, Year) 7/03/97				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REYNALDO ORJUELA-GOMEZ, M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204								
31. Date filed (Month, Day, Year) JUL 14 1997		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

97-3405-510

97-137

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Items: 23a part 1, 27, 28a-f per
JAMES THOMAS ROSS, JR.State of Maryland / Department of Health and Mental Hygiene
ME0 G-749 7/18/97 dh
Certificate of Death

97 21214

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James Thomas Ross, Jr.				2. Date of Death Month Day Year JUNE 20 1997		3. Time of Death 8:13 P.M.		
	4a. Facility Name (If not institution, give street and number) MARYLAND GENERAL HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death NA		
Funeral Director	5. Social Security Number 214-82-9777	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 39 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 02-05-58		9. Birthplace (State or Foreign Country) Md.	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Md	10b. County NA	10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number 131 East North Avenue			10f. Zip Code 21202		10g. Citizen of What Country? USA			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th Grade College (1-4 or 5+) NA		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cook		16b. Kind of Business/Industry Full-time				
	17. Father's Name (First, Middle, Last) James T. Ross, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Julia Giles				
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Gloria Moaney			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21239 1337 Sherwood Avenue Baltimore, Maryland					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Voshell Mem. Gardens		Date 07-12-97		20c. Location - City or Town, State Dundalk, Md.		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue					
	23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. COCAINE AND NARCOTIC INTOXICATION Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
Medical Certification: To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 6/20/97 found		28b. Time of Injury 7:30 found		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred subject ingested drugs
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JUNE 21, 1997		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz, MD 111 Penn Street, Baltimore, Maryland 21201								
State Registrar	31. Date filed (Month, Day, Year) JUL 14 1997								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

wlc
LILLIAN
RIECH

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21215

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LILLIAN MAY REICH				2. Date of Death Month Day Year July 8, 1997		3. Time of Death 8:00p	
	4e. Facility Name (If not institution, give street and number) 3406 MT PLEASANT AVENUE				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 217-01-2080	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 11, 1917		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 3406 Mt. Pleasant Avenue				10f. Zip Code 21224		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4or 5+) _____				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk			16b. Kind of Business/Industry Medical	
17. Father's Name (First, Middle, Last) John Moerschel				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Schmidt				
19a. Informant's Name/Relationship (Type, Print) Mrs. Karen E. Zukas, daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1510 Singer Road, Joppa, Md. 21085				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery		Date 7-11-97		20c. Location - City or Town, State Baltimore, Md.		
21. Signature of Funeral Service Licensee Ann S. Matthews				22. Name and Address of Facility Matthews Funeral Home 3021 Eastern Ave., Baltimore, Md. 21224				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e. Hypertensive Atherosclerotic Cardiovascular disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier [Signature]				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) July 9, 1997		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) JUL 14 1997				32. Registrar's Signature [Signature]				

Baltimore, Maryland 21215-0026
permit. Pages 1 and 2 should be filed within 72 hours and sent with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural or homicide" or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

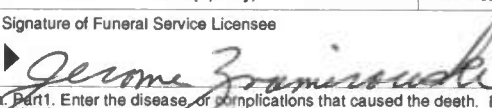
State
Registrar

Items: 23a part I, 27, 28a-f per MEO G-749 7/18/97 dh

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) Timothy John Riggins				2. Date of Death Month JULY Day 10 , Year 1997		3. Time of Death 0859AM	
4a. Facility Name (If not institution, give street and number) 117 PATRICIA AVENUE				4b. City, Town, or Location of Death LINTHICUM		4c. County of Death ANNE ARUNDEL	
5. Social Security Number 220 70 1616		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 40 Yrs.		8. Date of Birth (Month, Day, Year) August 15, 1956	
9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Linthicum	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 117 Patricia Avenue		10f. Zip Code 21090		10g. Citizen of What Country? U.S.	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Driver		16b. Kind of Business/Industry Trucking		17. Father's Name (First, Middle, Last) John A. Riggins	
18. Mother's Name (First, Middle, Maiden Surname) Betty J. Salley		19a. Informant's Name/Relationship (Type, Print) John Riggins / father		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 117 Patricia Avenue Linthicum, Maryland 21090		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial Park		20c. Date 7/14/97		20d. Location - City or Town, State Baltimore, Maryland		21. Signature of Funeral Service Licensee 	
22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MULTIPLE DRUG AND ALCOHOL INTOXICATION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) found 7/10/97		28b. Time of Injury unknown M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred subject ingested drugs and alcohol		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) home		28f. Location (Street and Number or Rural Route Number, City or Town, State) 117 Patricia Ave., Linthicum, Md.		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. Signature and title of certifier 		29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) JULY 11, 1997		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Aaron Lake, MD 111 Penn Street, Baltimore, Maryland 21201	
31. Date filed (Month, Day, Year) JUL 14 1997		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked "pending investigation", "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

[illegible]

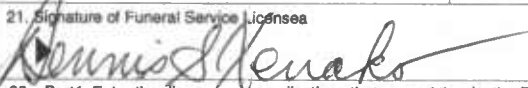
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21217

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JANE MAEYER SIMPSON				2. Date of Death Month July Day 9 Year 1997		3. Time of Death 926/pm	
	4a. Facility Name (If not institution, give street and number) THE UNION MEMORIAL HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 240-12-3958		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) August 10, 1915	9. Birthplace (State or Foreign Country) Pennsylvania
	Usual Residence of Decedent							
10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 4100 N Charles St				10f. Zip Code 21218		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/> 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home	
17. Father's Name (First, Middle, Last) Horace Chayne Maeyer				18. Mother's Name (First, Middle, Maiden Summa) Edith Miller				
19a. Informant's Name/Relationship (Type, Print) Jane Ann Simpson Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 769 E. Main St Purcellville, Virginia 20132				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Cemetery		Date 7/15/97		20c. Location - City or Town, State Baltimore, MARYLAND
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MYOCARDIAL INFARCTION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death 1 Hour
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
				28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		
				28b. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 		29c. License number D41699		29d. Date signed (Month, Day, Year) July 9, 1997
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDNA R. HILL, M.D. THE UNION MEMORIAL HOSPITAL, 201 EAST UNIVERSITY PKWY., BALTIMORE, MD 21218				31. Date filed (Month, Day, Year) JUL 14 1997				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural" or item 23a or 23b show any injury or other traumatic event, the medical examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21218

Certificate of Death

Reg. No.

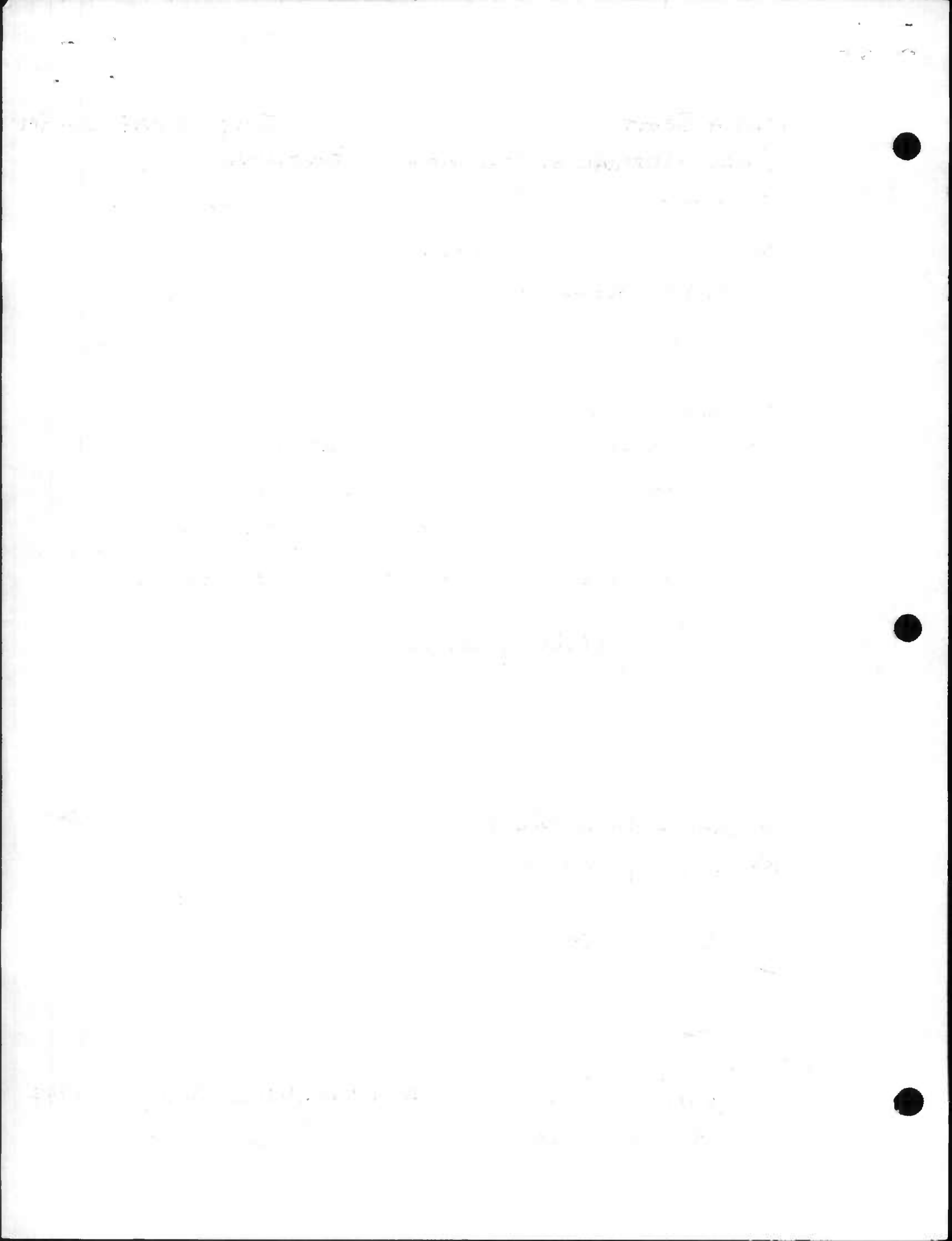
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CELA SCOTT				2. Date of Death Month July Day 10 Year 1997				3. Time of Death 650 PM	
	4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL of BALTIMORE				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death NA	
Funeral Director	5. Social Security Number 231-60-1140		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) 12-21-21	9. Birthplace (State or Foreign Country) VA
	Usual Residence of Decedent									
10a. State Md.		10b. County NA		10c. City, Town or Location Baltimore				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 4615 Park Heights Avenue				10f. Zip Code 21215			10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th Grade College (1-4 or 5+) NA				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home-maker			16b. Kind of Business/Industry in Home			
17. Father's Name (First, Middle, Last) John R. Burkley				18. Mother's Name (First, Middle, Maiden Surname) Estell Mitchell						
19a. Informant's Name/Relationship (Type, Print) James Scott				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2815 Kirk Avenue Baltimore, Maryland 21218						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Voshell Mem. Gardens 07-14-97 Dundalk, Md.								
21. Signature of Funeral Service Licensee Karen M. Hogen				22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Urinary Sepsis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____										Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Gastrointestinal bleed. Respiratory failure								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury 1 M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Michael J. [Signature]		29c. License number AS2402321N27023		29d. Date signed (Month, Day, Year) JULY 10 1997				
30. Name and address of person who completed cause of death (from 23a) (Type, Print) SINAI HOSPITAL of BALTIMORE 2401 W. Belvedere Ave. Baltimore, Md. 21215										
31. Date filed (Month, Day, Year) JUL 14 1997		32. Registrar's Signature John Davidson-Randall								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



97-3778-510

wlc

NORMAN

SHORTT, SR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21219

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) NORMAN FRANK SHORTT, Sr.				2. Date of Death Month July Day 9 Year 1997		3. Time of Death 1:13p	
	4a. Facility Name (If not institution, give street and number) 6102 EDLYNNE ROAD				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 216-44-2529		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 52 Yrs.		8. Date of Birth (Month, Day, Year) July 13, 1944	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 6102 Edlynn Road		10f. Zip Code 21239		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
Physician /Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver		16b. Kind of Business/Industry Electrical		17. Father's Name (First, Middle, Last) Bruce Elliott	
	18. Mother's Name (First, Middle, Maiden Surname) Anna Mildred Alton		19a. Informant's Name/Relationship (Type, Print) Judith Shortt (wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Dunhaven Place Apt. 1-C Baltimore, Maryland 21236		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
Physician /Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematory		20c. Date 7-12-97		20d. Location - City or Town, State Baltimore, Maryland		21. Signature of Funeral Service Licensee <i>George J. Ferrante</i>	
	22. Name and Address of Facility Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212		23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Atherosclerotic Cardiovascular Disease</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Medical Certification: To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Dennis J. Chute MD</i>		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) July 10, 1997	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201		31. Date filed (Month, Day, Year) JUL 14 1997		32. Registrar's Signature <i>Julia Davidson-Randall</i>			

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21220

Item 18 7-14-97 Film G749 W.H.Per F/H

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Simpkins				2. Date of Death Month July Day 10 Year 1997		3. Time of Death 8:25 pm	
	4a. Facility Name (If not institution, give street and number) Lorien Subacute Facility				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore City	
Funeral Director	5. Social Security Number 251-38-1140		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 31, 1927	
	9. Birthplace (State or Foreign Country) S.C.		10a. State MD		10b. County NA		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 15 Charles Plaza Apt. 902		10f. Zip Code 21201	
	10g. Citizen of What Country? USA				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) College	
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Merchant Seaman				16b. Kind of Business/Industry Nat. Maritime Union			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) MATTHEW Simpkins				18. Mother's Name (First, Middle, Maiden Surname) Mattie E. Lam			
	19a. Informant's Name/Relationship (Type, Print) David Simpkins - Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7805 Whistling Pines Ct. Ellicott City, Md 21043			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		20c. Location - City or Town, State 7-12-97 Balto Md	
	21. Signature of Funeral Service Licensee Stephen B. Harris				22. Name and Address of Facility March Funeral Home - West 4300 Wabash Ave Balto Md 21215			
To Be Completed by Physician/Medical Examiner	23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Septic Shock Due to (or as a consequence of): Pneumonia Due to (or as a consequence of): Hypertension Due to (or as a consequence of):				Approximate Interval Between Onset and Death 2 days 2 mos			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal failure Hypertension				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) July 11, 1997			
	28b. Time of Injury M				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Thomas J. Russi			
To Be Completed by Physician/Medical Examiner	29c. License number DS0785				29d. Date signed (Month, Day, Year) July 11, 1997			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas J. Russi 10805 Hickory Ridge Rd Columbia, MD				31. Date filed (Month, Day, Year) JUL 14 1997			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

30p

2

1. The first part of the paper is devoted to a general discussion of the problem.

2. In the second part, we consider the case of a single particle.

3. The third part is devoted to the case of a system of particles.

4. In the fourth part, we discuss the results of our calculations.

5. The fifth part is devoted to a discussion of the experimental results.

6. In the sixth part, we consider the case of a system of particles.

7. The seventh part is devoted to a discussion of the experimental results.

8. In the eighth part, we consider the case of a system of particles.

9. The ninth part is devoted to a discussion of the experimental results.

10. In the tenth part, we consider the case of a system of particles.

11. The eleventh part is devoted to a discussion of the experimental results.

12. In the twelfth part, we consider the case of a system of particles.

13. The thirteenth part is devoted to a discussion of the experimental results.

14. In the fourteenth part, we consider the case of a system of particles.

15. The fifteenth part is devoted to a discussion of the experimental results.

16. In the sixteenth part, we consider the case of a system of particles.

17. The seventeenth part is devoted to a discussion of the experimental results.

18. In the eighteenth part, we consider the case of a system of particles.

19. The nineteenth part is devoted to a discussion of the experimental results.

20. In the twentieth part, we consider the case of a system of particles.

21. The twenty-first part is devoted to a discussion of the experimental results.

22. In the twenty-second part, we consider the case of a system of particles.

23. The twenty-third part is devoted to a discussion of the experimental results.

24. In the twenty-fourth part, we consider the case of a system of particles.

25. The twenty-fifth part is devoted to a discussion of the experimental results.

26. In the twenty-sixth part, we consider the case of a system of particles.

27. The twenty-seventh part is devoted to a discussion of the experimental results.

28. In the twenty-eighth part, we consider the case of a system of particles.

29. The twenty-ninth part is devoted to a discussion of the experimental results.

30. In the thirtieth part, we consider the case of a system of particles.

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State of Maryland / Department of Health and Mental Hygiene

97 21221

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lucas E. Scott				2. Date of Death Month 7 Day 2 Year 97				3. Time of Death 1912					
	4a. Facility Name (If not Institution, give street and number) University of Maryland Medical System				4b. City, Town, or Location of Death Baltimore				4c. County of Death Baltimore					
Funeral Director	5. Social Security Number 215-78-6341		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 31 Yrs.		8. Date of Birth Month May Day 2 Year 1966		9. Birthplace (State or Foreign Country) Georgia					
	Usual Residence of Decedent													
To Be Completed by Funeral Director	10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
	10e. Street and Number 705 Newington Ave.				10f. Zip Code 21217				10g. Citizen of What Country? USA					
	11. Marital Status <input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck & Bus Driver				16b. Kind of Business/Industry Private Co.					
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Major Scott				18. Mother's Name (First, Middle, Maiden Summa) Martha I. Nix									
	19a. Informant's Name/Relationship (Type, Print) (mother) Mrs. Martha I. Scott				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1725 Richfield Dr. Severn Md. 21144									
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland National		20c. Date 7/8/97		20d. Location - City or Town, State Laurel, Md.							
	21. Signature of Funeral Service licensee Joseph L. Russ				22. Name and Address of Facility Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216									
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Endocarditis Due to (or as a consequence of): b. End stage renal disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last												Approximate Interval Between Onset and Death 3 day	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Human immunodeficiency virus												23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred				
				28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.														
29b. Signature and title of certifier Robert Ross, MD				29c. License number Res-000				29d. Date signed (Month, Day, Year) 7/2/97						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Ross, 22 S. Greene St. Baltimore, MD 21201														
31. Date filed (Month, Day, Year) JUL 14 1997				32. Registrar's Signature John Davidson-Randall										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21222

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Shernell Towanda Small-Bey				2. Date of Death Month Day Year JULY 09, 1997		3. Time of Death 10:20 A			
	4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL ICU				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death NTA			
Funeral Director	5. Social Security Number 216-84-6859		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 24 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 3, 1973	9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number 2110 W. Patapsco Ave.		10f. Zip Code 21230		10g. Citizen of What Country? USA					
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. African American			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cashier		16b. Kind of Business/Industry Food Industry					
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Kevin C. Chase				18. Mother's Name (First, Middle, Maiden Surname) Debra Small					
	19a. Informant's Name/Relationship (Type, Print) (mother) Mrs. Debra Morton-Bey				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2110 W. Patapsco Ave. Balto. Md. 21230					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Voshell Mem. Gardens		20c. Location - City or Town, State 7/19/97 Dundalk, Md.					
	21. Signature of Funeral Service Licensee Joseph L. Russ		22. Name and Address of Facility Joseph L. Russ Funeral Home 2322 W. North Ave. Balto. Md. 21216							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Contact Gunshot Wound of Head Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) found 7/8/97		28b. Time of Injury found 11:00M		28c. Injury et Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred subject was shot subject shot herself	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) found at home				28f. Location (Street and Number or Rural Route Number, City or Town, State) 2705 Ruscombe Lane Baltimore, Maryland			
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Dennis J. Chute, MD		29c. License number OCME		29d. Date signed (Month, Day, Year) JULY 10, 1997			
State Registrar	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201									
	31. Date filed (Month, Day, Year) JUL 14 1997		32. Registrar's Signature Julia Davidson-Randall							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 21223**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Joan Miriam Skeans

2. Date of Death

Month
JULYDay
10,Year
1997

3. Time of Death

3:01 am

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

115-24-8681

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

64

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
08/13/1932

9. Birthplace (State or Foreign Country)

N.Y.

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Hunt Valley

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street end Number

1 Furnace Court

10f. Zip Code

21030

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
White15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

George Dougherty

18. Mother's Name (First, Middle, Maiden Surname)

Harriet Gross

19a. Informant's Name/Relationship (Type, Print)

Francis W. Skeans (husband)

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)

1 Furnace Court Hunt Valley, MD. 21030

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Hilltop Service Corp.

Date

7/12/97

20c. Location - City or Town, State

Towson, MD.

21. Signature of Funeral Service Licensee

Dean C. Canall

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.

1050 York Rd. Towson, MD. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Cardiopulmonary arrest
Due to (or as a consequence of):Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. metastatic lung cancer
Due to (or as a consequence of):c. _____
Due to (or as a consequence of):d. _____
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

1 hour

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street end Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Robert Stoltz, M.D.

29c. License number

D30910

29d. Date signed (Month, Day, Year)

7/10/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Stoltz 1447 York Rd. Lutherville, MD.

31. Date filed (Month, Day, Year)

JUL 14 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

SKEANS, JOAN M.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21224

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BERNARD SOBOTKA				2. Date of Death Month JULY Day 11 Year 1997		3. Time of Death 11:36 PM	
	4a. Facility Name (If not institution, give street and number) The Good Samaritan Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 213-28-6883		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 65 Yrs.		8. Date of Birth (Month, Day, Year) 09/13/1931	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 2204 Louise Avenue		10f. Zip Code 21214		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Korea		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Longshoreman		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Port of Baltimore		16b. Kind of Business/Industry Port of Baltimore		17. Father's Name (First, Middle, Last) Vincent Sobotka		
18. Mother's Name (First, Middle, Maiden Surname) Laura Dez		19a. Informant's Name/Relationship (Type, Print) Mrs. Patricia C. Sobotka / Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2204 Louise Avenue Baltimore, Maryland 21214		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) Moreland Memorial Park		20c. Date 7/16/97		20d. Location - City or Town, State Baltimore, Maryland		21. Signature of Funeral Service Licensee Mark T. Zavoyna		
22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CARDIOGENIC SHOCK		Approximate Interval Between Onset and Death 17 HOURS		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
23c. Immediate Cause (Final disease or condition resulting in death) ACUTE MYOCARDIAL INFARCTION		Due to (or as a consequence of): 17 HOURS		Due to (or as a consequence of):		Due to (or as a consequence of):		
23d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or as a consequence of):		Due to (or as a consequence of):		Due to (or as a consequence of):		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Richard M.D.		29c. License number P10582		29d. Date signed (Month, Day, Year) JULY 11, 1997		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANN MECHERIKUNNEL, 5601, LOCH RAVEN BLVD., BALTO., MD 21239		31. Date filed (Month, Day, Year) JUL 14 1997		32. Registrar's Signature Julia [Signature]				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed in the office of the Registrar of the Department of Health and Mental Hygiene. If item 27 is marked other than "Natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at the office.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21225

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Theresa D. Schulte

2. Date of Death

July

Day

Year

1997

3. Time of Death

9:30 pm

4a. Facility Name (If not institution, give street and number)

3019 Third Ave

4b. City, Town, or Location of Death

Parkville

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

219 01 5829

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 16 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3019 Third Ave

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16e. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

William Wallace Dakin

18. Mother's Name (First, Middle, Maiden Surname)

Mary M. Trayser

19e. Informant's Name/Relationship (Type, Print)

Delores Schulte

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3019 Third Ave. Parkville Maryland 21234

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Most Holy Redeemer Cemetery

Date

July 12

1997

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Evans Chapel of Memories

8800 Harford Rd. Baltimore Md. 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Arteriosclerotic coronary artery disease

Due to (or as a consequence of):

b. Diabetes Mellitus

Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Peripheral Vascular disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24e. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28e. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] Marion Kowalewski MD

29c. License number

D21022

29d. Date signed (Month, Day, Year)

7-10-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Marion Kowalewski MD. 8604 Harford Rd. Baltimore, Md.

31. Date filed (Month, Day, Year)

JUL 14 1997

32. Registrar's Signature

[Signature] Julia Davidson-Rendall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "Natural" or item 23a or 23e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21226

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GLADYS MAY TRAPP				2. Date of Death Month Day Year JUL 9 1997		3. Time of Death 9:30 am	
	4a. Facility Name (If not institution, give street and number) 1010 HILLPINE ROAD				4b. City, Town, or Location of Death MIDDLE RIVER		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 219-10-6119		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) JUL 18 1916	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MARYLAND		10b. County BALTIMORE		10c. City, Town or Location MIDDLE RIVER	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 1010 HILLPINE ROAD		10f. Zip Code 21220		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th grade College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CLERK		16b. Kind of Business/Industry GROCERY STORE				
17. Father's Name (First, Middle, Last) GEORGE HALL				18. Mother's Name (First, Middle, Maiden Surname) IDA MAE JOHNSON				
19a. Informant's Name/Relationship (Type, Print) Virginia M. Preston/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1004 Hillpine Road, Baltimore, Maryland 21220				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HOLLY HILLS MEM. GARD.		20c. Location - City or Town, State 7-14 MIDDLE RIVER, MARYLAND				
21. Signature of Funeral Service Licensee <i>William C. Brown</i>				22. Name and Address of Facility WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Colon Carcinoma Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Approximate Interval Between Onset and Death 11 mths								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>M. J. M.D.</i>				29c. License number D18407		29d. Date signed (Month, Day, Year) 7/11/97		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MYO THANT 6830 HOSPITAL DRIVE, BALTIMORE, MD 21237								
31. Date filed (Month, Day, Year) JUL 14 1997				32. Registrar's Signature <i>John Davidson-Randall</i>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

AM
ARTHUR
TURNER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21227

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Arthur E. Turner				2. Date of Death Month JULY Day 10 Year 1997		3. Time of Death 7:32 P		
	4a. Facility Name (If not institution, give street and number) 2121 WINDSORGARDEN LA. APT. C432				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A		
Funeral Director	5. Social Security Number 212-28-0636		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 65 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 25, 1932 Md.		
	10a. State Md.		10b. County N/A		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
15. Decedent's Education (Specify only highest grade completed) Grade				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pipe Fitter				16b. Kind of Business/Industry American Smelting & Refining Co.	
17. Father's Name (First, Middle, Last) John Turner				18. Mother's Name (First, Middle, Maiden Surname) Fannie Pye					
19a. Informant's Name/Relationship (Type, Print) daughter Yvette Jackson-Bey				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 408 Village Of Pine Ct. Apt 3B Balto., Md. 21244					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Veterans				20c. Location - City or Town, State July 15 Owings Mills, Md.	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? INSPECTION <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
				28d. Describe how injury occurred					
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 				29c. License number OCME		29d. Date signed (Month, Day, Year) JULY 11, 1997			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) JUL 14 1997				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21228
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Isaac Toon				2. Date of Death Month Day Year JULY 11, 1997		3. Time of Death 16:04 p	
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death N/A	
Funeral Director	5. Social Security Number 246-20-6169		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) April 3, 1925	
	9. Birthplace (State or Foreign Country) North Carolina		10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 2520 Harford Rd.		10f. Zip Code 21218		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: African American	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer		16b. Kind of Business/Industry Pittsburgh Glass Co.			
	17. Father's Name (First, Middle, Last) John Toon				18. Mother's Name (First, Middle, Maiden Surname) Lottie Lewis			
	19a. Informant's Name/Relationship (Type, Print) (niece) Mrs. Theatus Houston				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5421 Jonquil Ave. Balto, Md. 21215			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Druid Ridge		20c. Location - City or Town, State 7/19/97 Balto. Md.			
	21. Signature of Funeral Service Licensee Joseph L. Russ				22. Name and Address of Facility Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): b. liver failure Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Approximate Interval Between Onset and Death 3 days 2 years							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Tully Alfo, Senior Resident				29c. License number RES-000		29d. Date signed (Month, Day, Year) July 14, 1997		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Kelly Gcho 601 North Wolfe St, Baltimore, MD 21287								
31. Date filed (Month, Day, Year) JUL 14 1997		32. Registrar's Signature John Davidson-Randall						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21229

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Barthonia N. Taylor, Jr.				2. Date of Death Month: JULY Day: 10 Year: 1997		3. Time of Death 2:15 am														
	4e. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death NA														
Funeral Director	5. Social Security Number 224-58-7565		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 52 Yrs.		8. Date of Birth (Month, Day, Year) 9-9-44														
	9. Birthplace (State or Foreign Country) La.		10a. State MD		10b. County NA		10c. City, Town or Location Baltimore														
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 1920 Cecil Ave		10f. Zip Code 21218		10g. Citizen of What Country? U.S.A														
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black														
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 6th grade College (1-4 or 5+): NA		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) COOK		16b. Kind of Business/Industry Facilities																
	17. Father's Name (First, Middle, Last) Barthonia Nelson, Taylor Sr.				18. Mother's Name (First, Middle, Maiden Surname) Pearl Yancy																
	19a. Informant's Name/Relationship (Type, Print) Bobbie Jean Wilson				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 817 Gilrubin Ct Apt 11, Balto., MD 21212																
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):		20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Cem.		Date 7-12-97		20c. Location - City or Town, State Baltimore, MD														
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility March F. H. EAST 1101 E. North Ave																
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																				
	<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Sepsis</td> <td>Approximate Interval Between Onset and Death 48 hours</td> </tr> <tr> <td>b.</td> <td>Liver Failure</td> <td>5 years</td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	Sepsis	Approximate Interval Between Onset and Death 48 hours	b.	Liver Failure	5 years	c.			d.		
	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	Sepsis	Approximate Interval Between Onset and Death 48 hours																	
b.		Liver Failure	5 years																		
c.																					
d.																					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown																					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined																					
28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																					
28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)																					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																					
29b. Signature and title of certifier <i>[Signature]</i> MD																					
29c. License number RES.000																					
29d. Date signed (Month, Day, Year) July 10, 1997																					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD. BREWSTER JOHNS HOPKINS HOSPITAL 600 N. Wolfe Street 21287																					
31. Date filed (Month, Day, Year) JUL 14 1997																					
32. Registrar's Signature <i>[Signature]</i>																					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

THEODORE A.
THOMAS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21230

Item 5 per FH Film G749 7-15-97 rja

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Theodore Anthony Thomas				2. Date of Death Month JULY Day 12 Year 1997		3. Time of Death 3:25 PM.	
	4a. Facility Name (If not institution, give street and number) 1345 GORSUCH AVE.				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death NA	
Funeral Director	5. Social Security Number 215-415-30-9999	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 63 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 06-23-34		9. Birthplace (State or Foreign Country) Md.
	Usual Residence of Decedent							
10a. State Md		10b. County NA		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 1345 Gorsuch Avenue				10f. Zip Code 21218		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) 1 year				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Porter		16b. Kind of Business/Industry Lexington Market		
17. Father's Name (First, Middle, Last) Theodore R. Thomas				18. Mother's Name (First, Middle, Maiden Surname) Frances Bowman				
19a. Informant's Name/Relationship (Type, Print) Patricia Bowles Thomas				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218 1345 Gorsuch Avenue Baltimore, Maryland				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Cemetery		Data 07-16-97		20c. Location - City or Town, State Baltimore, Md.		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Arteriosclerotic Cardiovascular Disease a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JULY 13, 1997		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) JUL 14 1997				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

WRC
97-3797-510
VINCENT
VENDETTI

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21231

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Marshal Vincent Vendetti				2. Date of Death Month Day Year JULY 10, 1997		3. Time of Death 5:10 PM	
	4a. Facility Name (If not institution, give street and number) 5028 E. EAGER ST.				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death	
Funeral Director	5. Social Security Number 220-72-4736		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 38 Yrs.		8. Date of Birth (Month, Day, Year) Feb 24, 1959	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Baltimore City		10c. City, Town or Location Baltimore City	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 5028 E. Eager St.		10f. Zip Code 21205		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Entertainer		16b. Kind of Business/Industry Show Business				
17. Father's Name (First, Middle, Last) William J. Vendetti				18. Mother's Name (First, Middle, Maiden Surname) Diana Re				
19a. Informant's Name/Relationship (Type, Print) William J. Vendetti (Father)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1329 Amyclae Place Belair, Maryland 21014				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Crematory 7/15/1997		20c. Date 7/15/1997		20d. Location - City or Town, State Baltimore Md.		
21. Signature of Funeral Service Licensee <i>John W. Burkowski</i>		22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Contant Gunshot Wound to Chest Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) UNK		28b. Time of Injury UNK M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred Subject shot self		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) AT HOME		28f. Location (Street and Number or Rural Route Number, City or Town, State) 5028 E. Eager St. 21205				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Dr. [Signature]		29b. Signature and title of certifier		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JULY 11, 1997		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) T. [Signature] 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) JUL 14 1997								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed with the death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "Natural", items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21232

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edwin

VESTAL

2. Date of Death

Month Day Year
July 13, 1997

3. Time of Death

11:07 am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

216-20-3437

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Jan. 3, 1926

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2027 Middleborough Rd.

10f. Zip Code

21221

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Food Store

17. Father's Name (First, Middle, Last)

William C. Vestal

18. Mother's Name (First, Middle, Maiden Surname)

Carrie G. Lang

19a. Informant's Name/Relationship (Type, Print)

Beulah Vestal (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2027 Middleborough Rd. Baltimore, Md. 21221

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

20c. Location - City or Town, State

Holly Hill Mem. Gardens 7/15/1997 Baltimore Co. Md.

21. Signature of Funeral Service Licensee

John W. Burkowski

22. Name and Address of Facility

Bruzdinski Funeral Home P.A.

1407 Old Eastern Avenue Essex, Md. 21221

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Respiratory Failure

Approximate Interval Between Onset and Death

10 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

Chronic Obstructive Pulmonary Disease/Emphysema

b. Due to (or as a consequence of):

Smoking Cigarettes

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Daniel Alexander M.D.

29c. License number

RD2335

29d. Date signed (Month, Day, Year)

July 13, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daniel Alexander M.D. 9000 Franklin Square Drive Baltimore, Maryland 21237

31. Date filed (Month, Day, Year)

JUL 14 1997

32. Registrar's Signature

John Burkowski-Randall

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitBaltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", forms 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

11/11

11/11

X

X

X

X

X

X

11/11

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21233

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Steve VORIAS				2. Date of Death Month Day Year July 10, 1997		3. Time of Death 9:00 am	
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center				4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 191-12-5910		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 3, 1923	
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 8314 Sagamore Road		10f. Zip Code 21237	
	10g. Citizen of What Country? U.S.A.				11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Inspector				16b. Kind of Business/Industry Steel			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Michael Vorias				18. Mother's Name (First, Middle, Maiden Surname) Argiro Kariambis			
	19a. Informant's Name/Relationship (Type, Print) Mrs. Harriet Vorias, wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8314 Sagamore Road, Baltimore, Md. 21237			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery		20c. Location - City or Town, State Baltimore, Md.	
	21. Signature of Funeral Service Licensee Ann S. Matthews				22. Name and Address of Facility Matthews Funeral Home 3021 Eastern Ave., Baltimore, Md. 21224			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia Due to (or as a consequence of): Cerebrovascular Accident Due to (or as a consequence of): Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 3 Weeks 5 Weeks 10 Years			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Obstructive Pulmonary Disease, Diabetes Mellitus, Hypothyroidism, Congestive Cardiomyopathy, Hypertension				23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
	28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
To Be Completed by Physician/Medical Examiner	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
	29b. Signature and title of certifier John Loh M.D.				29c. License number H35593		29d. Date signed (Month, Day, Year) July 10, 1997	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Loh M.D. 1124 Mace Avenue Baltimore, Maryland 21221				31. Date filed (Month, Day, Year) JUL 14 1997			
	32. Registrar's Signature John Loh M.D.				33. Registrar's Signature John Loh M.D.			

97 51333

11/11

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21234

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret Elizabeth Vaughn				2. Date of Death Month July Day 14 Year 1997				3. Time of Death 3:00 pm.	
	4a. Facility Name (If not institution, give street and number) 1 Mill Paint Lane, Apt. 1A				4b. City, Town, or Location of Death Owings Mills				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 215-32-7117		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) March 12, 1914		9. Birthplace (State or Foreign) Maryland		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Owings Mills	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 1 Mill Paint Lane, Apt. 1A		10f. Zip Code 21117		10g. Citizen of What Country? U.S.A.		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife	
	16b. Kind of Business/Industry Homemaker		17. Father's Name (First, Middle, Last) Walter I. Berryman		18. Mother's Name (First, Middle, Maiden Surname) Agnes Leaf		19a. Informant's Name/Relationship (Type, Print) Nancy Nunn - daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Mill Paint Lane, Apt. 1A, Owings Mills, Md. 21117	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) LakeView Mem. Park		Date July 14, 1997		20c. Location - City or Town, State Sykesville, Md.		21. Signature of Funeral Service Licensee J. S. S. S. S.	
	22. Name and Address of Facility Eckhardt Funeral Chapel		22. Name and Address of Facility 11605 Reisterstown Rd. Owings Mills, Md. 21117		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. metastatic Ca of the Kidney		Approximate Interval Between Onset and Death 8 mo		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
	28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier M. Benest MD		29c. License number D16941		29d. Date signed (Month, Day, Year) 7/11/97	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 21 Crossroads Dr. Owings Mills, Md 21117		31. Date filed (Month, Day, Year) JUL 14 1997		32. Registrar's Signature J. S. S. S. S.		33. Registrar's Signature J. S. S. S. S.		34. Registrar's Signature J. S. S. S. S.	

Baltimore, Maryland 21215-0020
perm. Pages 1 and 2 should be filed with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Division of Vital Records, P.O. Box 68760,
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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ASUDD

1. The first part of the report

concerns the general situation

of the country and its people

and the progress of the work

done during the last year

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21235

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JAMES WELDON				2. Date of Death Month Day Year JULY 10, 1997		3. Time of Death 4:26PM																															
	4e. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A																															
Funeral Director	5. Social Security Number 220-36-8374		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 56 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 21, 1941																															
	9. Birthplace (State or Foreign Country) Md.		10. Usual Residence of Decedent 10a. State Md. 10b. County N/A 10c. City, Town or Location Baltimore 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 2636 Garrett Avenue		10f. Zip Code 21218																															
To Be Completed by Funeral Director	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black																															
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th Grade College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver		16b. Kind of Business/Industry Furniture Store																																	
	17. Father's Name (First, Middle, Last) James Mustafah				18. Mother's Name (First, Middle, Maiden Surname) Madeline Payne																																	
	19a. Informant's Name/Relationship (Type, Print) James Mustafah father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1301 Lakeside Avenue Baltimore, Md. 21218																																	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park		20c. Location - City or Town, State July 14 Baltimore, Md.																																	
	21. Signature of Funeral Service Licensee <i>Ernest R. Ferry, Jr.</i>				22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216																																	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																					
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td colspan="6">e. Cryptococcal Meningitis Due to (or as a consequence of):</td> <td>1 month</td> </tr> <tr> <td rowspan="3">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td colspan="6">b. Staphylococcal Bacteremia Due to (or as a consequence of):</td> <td>3 days</td> </tr> <tr> <td colspan="6">c. Acquired Immunodeficiency Syndrome Due to (or as a consequence of):</td> <td>3 years</td> </tr> <tr> <td colspan="6">d.</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	e. Cryptococcal Meningitis Due to (or as a consequence of):						1 month	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Staphylococcal Bacteremia Due to (or as a consequence of):						3 days	c. Acquired Immunodeficiency Syndrome Due to (or as a consequence of):						3 years	d.						
	Immediate Cause (Final disease or condition resulting in death)	e. Cryptococcal Meningitis Due to (or as a consequence of):						1 month																														
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Staphylococcal Bacteremia Due to (or as a consequence of):							3 days																												
c. Acquired Immunodeficiency Syndrome Due to (or as a consequence of):						3 years																																
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24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																																						
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																																			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																															
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred																																	
			28f. Location (Street and Number or Rural Route Number, City or Town, State)																																			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																																					
29b. Signature and title of certifier <i>Shannon Purman</i>				29c. License number RES-000		29d. Date signed (Month, Day, Year) July 10, 1997																																
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Shannon Purman, Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore																																						
31. Date filed (Month, Day, Year) JUL 14 1997		32. Registrar's Signature <i>Lelia Davidson-Randall</i>																																				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Medical or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit certificate filed in by the funeral director.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21236

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DEBORAH LYNN WANKEL				2. Date of Death Month Day Year July 10, 1997		3. Time of Death 11:48 AM							
	4e. Facility Name (If not institution, give street and number) University of Maryland				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A							
Funeral Director	5. Social Security Number 218-96-4171		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 29 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Apr. 13, 1968		9. Birthplace (State or Foreign Country) Md.					
	Usual Residence of Decedent													
10a. State Md.		10b. County Baltimore		10c. City, Town or Location Timonium				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
10e. Street and Number 13 F Mistywood Circle				10f. Zip Code 21093		10g. Citizen of What Country? USA								
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Property Specialist			16b. Kind of Business/Industry Dept. of Defense							
17. Father's Name (First, Middle, Last) Richard Wankel				18. Mother's Name (First, Middle, Maiden Surname) Mary Gier										
19a. Informant's Name/Relationship (Type, Print) Mary Wankel/mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Elphin Ct. #101 Timonium, Md. 21093										
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp.		Date 7/14/97		20c. Location - City or Town, State Towson, Md. 21204								
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Respiratory Distress Syndrome Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death 30 days					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes									23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred						
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									29b. Signature and title of certifier Dylan Stewart, MD		29c. License number P10249		29d. Date signed (Month, Day, Year) 07 11 97	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dylan Stewart, MD University of Maryland									31. Date filed (Month, Day, Year) JUL 14 1997		32. Registrar's Signature Julia Davidson-Randall			

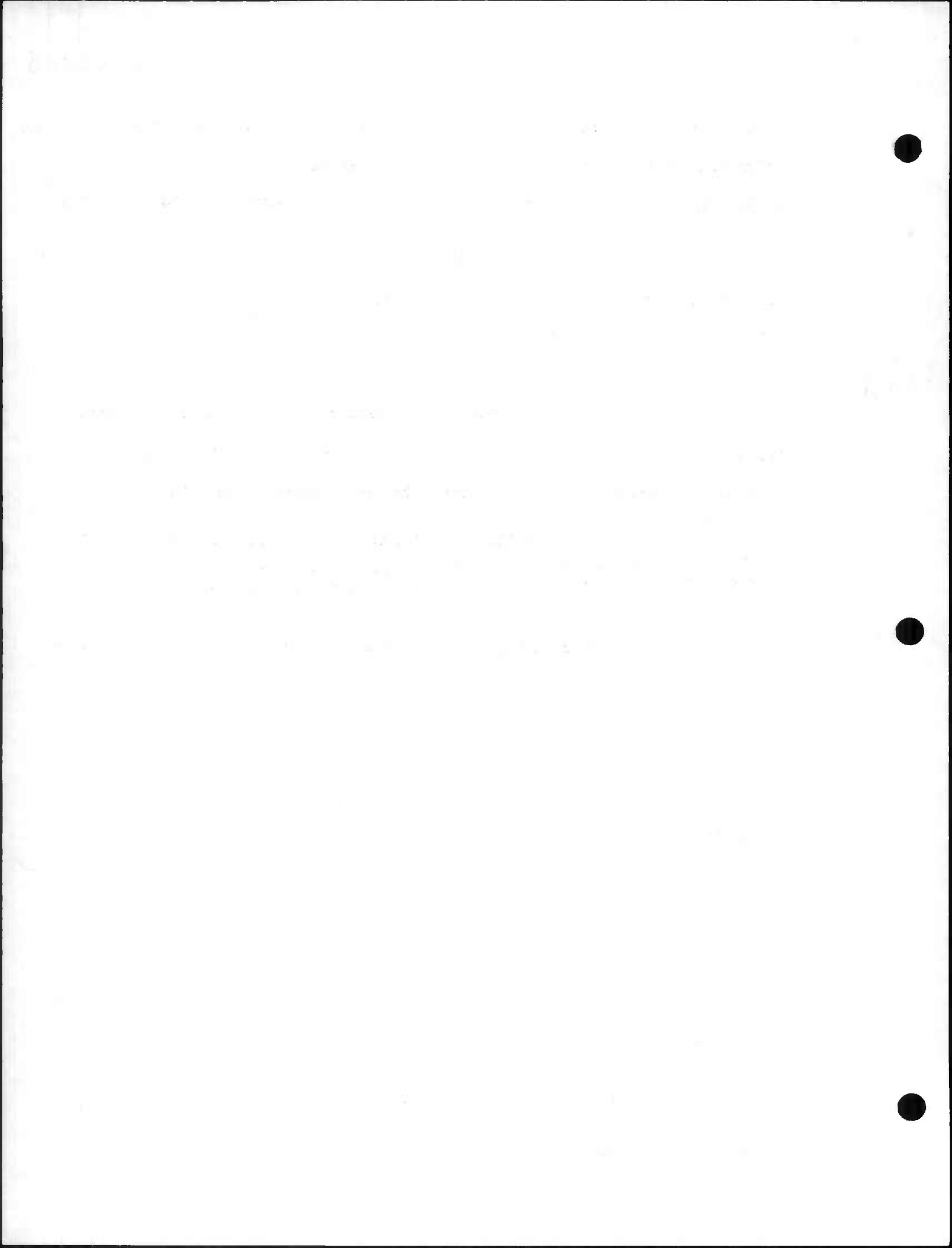
Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than natural or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21237

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SYLVIA E WARD				2. Date of Death Month JUL Day 10 Year 1997		3. Time of Death 10 47 AM	
	4e. Facility Name (If not institution, give street and number) University of Maryland Hospital				4b. City, Town, or Location of Death Baltimore City		4c. County of Death N/A	
Funeral Director	5. Social Security Number 219-82-3839		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 37 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 10, 1959	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Dundalk	
To Be Completed by Funeral Director	10e. Street and Number 7910 Wallace Road		10f. Zip Code 21222		10g. Citizen of What Country? United States		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 Years College (1-4 or 5+) 2 Years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary		16b. Kind of Business/Industry Law Firm		17. Father's Name (First, Middle, Last) Clarence Hosler	
	18. Mother's Name (First, Middle, Maiden Surname) Betty McQuay		19e. Informant's Name/Relationship (Type, Print) Mr. Steve T. Ward/Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7910 Wallace Road Dundalk, Maryland 21222		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
Physician /Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery		20c. Date 7/14/1997		20d. Location - City or Town, State Baltimore, MD		21. Signature of Funeral Service Licensee 	
	22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Cerebral Herniation Syndrome Due to (or as a consequence of): b. Angiosarcoma Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death 2 days 6 months		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0060	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28e. Date of Injury (Month, Day Year) 7/14/1997		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be retained in the office of the funeral director.	28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 	
	29c. License number P04997		29d. Date signed (Month, Day, Year) JUL 10 1997		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 22 S. GREENE ST S-12-D BALTIMORE, MD 21201		31. Date filed (Month, Day, Year) JUL 14 1997	
State Registrar	32. Registrar's Signature 							

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gilbert Alonzo Wiley				2. Date of Death Month Day Year JULY 07, 1997		3. Time of Death 1745PM		
	4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death NA		
Funeral Director	5. Social Security Number 212-82-9695		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 32 Yrs.		8. Date of Birth (Month, Day, Year) 08-23-64		
	9. Birthplace (State or Foreign Country) Md.		10a. State Md.		10b. County NA		10c. City, Town or Location Baltimore		
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 5231 Tramore Road		10f. Zip Code 21214		
	10g. Citizen of What Country? USA				11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) NA		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Telemarketing				16b. Kind of Business/Industry Sears Dept. Store				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Gilbert L. Wiley				18. Mother's Name (First, Middle, Maiden Surname) Linda Chase				
	19a. Informant's Name/Relationship (Type, Print) Linda Wiley				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5231 Tramor Road Baltimore, Maryland 21214				
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest VA Cem. 07-14-97 Owings Mills		20c. Location - City or Town, State Md.		
	21. Signature of Funeral Service Licensee <i>Vanessa Cook</i>				22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue				
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Blunt Force Injury of head and Multiple Cutting Wounds</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 7/6/97		28b. Time of Injury 2:15 PM		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	28d. Describe how injury occurred <i>subject of beaten and cut</i>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i>street</i>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>906 Belger Ave Baltimore, Md</i>		28g. Location (Street and Number or Rural Route Number, City or Town, State)		
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							29b. Signature and title of certifier <i>Dennis J. Chute MD</i>	
	29c. License number O.C.M.E.							29d. Date signed (Month, Day, Year) JULY 09, 1997	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201							31. Date filed (Month, Day, Year) JUL 14 1997	
	32. Registrar's Signature <i>Johanna Wilson-Randall</i>							33. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 21239

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Blanche Irene Wright				2. Date of Death Month July Day 6 , Year 1997		3. Time of Death 1:00 AM		
	4a. Facility Name (If not institution, give street and number) 17105 York Road				4b. City, Town, or Location of Death Parkton		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 216-98-4903		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 24, 1922	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent:								
To Be Completed by Funeral Director	10a. State MD	10b. County Baltimore		10c. City, Town or Location Parkton			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 17105 York Road			10f. Zip Code 21120		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Domestic		
	17. Father's Name (First, Middle, Last) Walter S. Barrett				18. Mother's Name (First, Middle, Maiden Surname) Mary L. Wheeler				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) W. Herbert Wright/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 635, New Freedom, PA 17349				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Memorial Gardens		Date July 9, 1997		20c. Location - City or Town, State Timonium, MD		
	21. Signature of Funeral Service Licensee <i>J.J. Hartenstein</i>				22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Coronary Artery Disease</i> Due to (or as a consequence of): b. <i>Atherosclerosis</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	Approximate Interval Between Onset and Death years years								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
		28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Mark Lamos MD		29c. License number D34521		29d. Date signed (Month, Day, Year) 7-7-97			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Mark Lamos, MD 9 Shilling Rd., Hunt Valley, MD									
31. Date filed (Month, Day, Year) JUL 14 1997		32. Registrar's Signature <i>Julian Davidson-Randall</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21240

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

James A. Williamson

2. Date of Death

Month

Day

Year

July

3

1997

3. Time of Death

2:40 PM

4a. Facility Name (If not institution, give street and number)

Veterans Administration Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

216 16 6541

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

8/17/23

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☐ Yes 2 ☐ No

10e. Street and Number

2726 BAKER ST.

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates:

3/43

10/45

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: AFRO

AMERICAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

FOREMAN (RETIRED)

16b. Kind of Business/Industry

CALVERT DISTILLERY

17. Father's Name (First, Middle, Last)

SIDNEY WILLIAMSON

18. Mother's Name (First, Middle, Maiden Surname)

CARRIE HONEYBEE

19a. Informant's Name/Relationship (Type, Print)

HELEN WILLIAMSON WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2726 Baker St. BALTIMORE, MD. 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARBUTUS MEM. PARK

Date

7/8/97

20c. Location - City or Town, State

ARBUTUS, MD.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

ESTEP BROTHERS FUNERAL HOME P.A.
1300 EUTAW PL. BALTO. MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

2 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Chronic Renal Failure

Due to (or as a consequence of):

1 yr

c. Bacteremia

Due to (or as a consequence of):

1 week

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] Scott Huber MD

29c. License number

P09738

29d. Date signed (Month, Day, Year)

July 3, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Scott Huber, M.D. 20 N. Green St Baltimore, MD 21201

31. Date filed (Month, Day, Year)

JUL 14 1997

32. Registrar's Signature

[Signature] Julia Davidson-Randall

State Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be retained for 10 years after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21241

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GEORGE F. ZIZWAREK		2. Date of Death Month JULY Day 11 Year 1997		3. Time of Death 0130 AM
	4e. Facility Name (If not institution, give street and number) GOOD SAMARITAN HOSPITAL		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A
Funeral Director	5. Social Security Number 213-20-8347	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) April 11 1925		9. Birthplace (State or Foreign Country) Maryland		
Usual Residence of Decedent					
10e. State Md.		10b. County N/A		10c. City, Town or Location Baltimore City	
10e. Street and Number 6001 Glenoak Avenue		10f. Zip Code 21214		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrician	
16b. Kind of Business/Industry Contractor		17. Father's Name (First, Middle, Last) John G. Zizwarek		18. Mother's Name (First, Middle, Maiden Surname) Emma M. Stamp	
19e. Informant's Name/Relationship (Type, Print) Elizabeth E. Zizwarek (Wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6001 Glenoak Ave. Baltimore, Maryland 21214			
20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Moreland Memorial Park		20c. Location - City or Town, State Baltimore Maryland	
21. Signature of Funeral Service Licensee Milton J. Knight Jr.		22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Md. 21214			
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SEPSIS Due to (or as a consequence of): SIX DAYS					
23f. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ATRIAL FIBRILLATION, END STAGE RENAL DISEASE, CHRONIC OBSTRUCTIVE PULMONARY DISEASE					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier HOUSESTAFF					
29c. License number P09308					
29d. Date signed (Month, Day, Year) JULY 11, 1997					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YVETTE TALUSAN, M.D. 5601 LOCHRAVEN BLVD., BALTIMORE, MD 21239-2995					
31. Date filed (Month, Day, Year) JUL 14 1997					
32. Registrar's Signature John Davidson-Randall					

Baltimore, Maryland 21215-0020
To Be Completed by Funeral DirectorPhysician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21242

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret M. Adams

2. Date of Death

Month Day Year
JUNE 25 1997

3. Time of Death

11:10 P.M.

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

219-20-9949

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
08-13-1918

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

PASADENA

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

206 TENTH STREET

10f. Zip Code

21122

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

ARTHUR RAYMOND GARDNER

18. Mother's Name (First, Middle, Maiden Surname)

CATHERINE ANNA TRIMPER

19a. Informant's Name/Relationship (Type, Print)

EDWARD L. CHANEY (GRANDSON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

104 CHARLGATE ROAD, OWINGS MILLS, MD 21117

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

GLEN HAVEN MEMORIAL PARK 6/28/97

Date

20c. Location - City or Town, State

GLEN BURNIE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SINGLETON FUNERAL HOME
1 SECOND AVE. S.W., GLEN BURNIE, MD 2106123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. SMALL CELL LUNG CANCER

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

4 weeks

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEEP VEIN THROMBOSIS

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D43977

29d. Date signed (Month, Day, Year)

JUNE 25 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Cyprien Dueton, 301 HOSPITAL DRIVE, GLEN BURNIE MD 21061

31. Date filed (Month, Day, Year)

JUL 01 1997

32. Registrar's Signature

Julia Burton-Randall

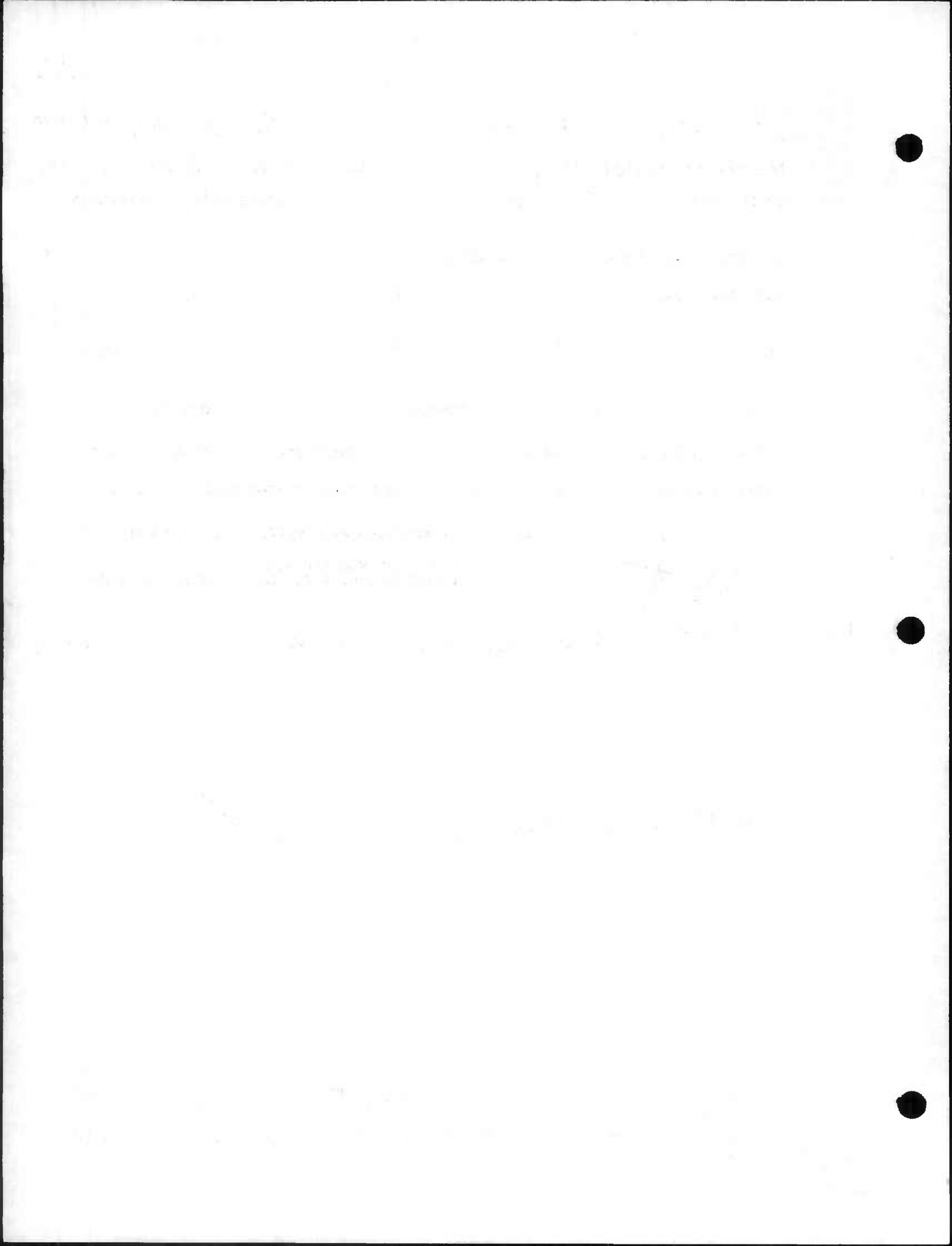
State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21243

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

VERNA

C

ANGELLATTA

2. Date of Death
Month

JUNE

Day

30

Year

1997

3. Time of Death

8:42 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL ASSN

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

234-34-1421

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov 8, 1923

9. Birthplace (State or Foreign

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8387 Bodkin Avenue

10f. Zip Code

21122

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary Secondary (0-12)

12

College (1-4 or 5+)

16. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Leslie Carver

18. Mother's Name (First, Middle, Maiden Surname)

Pearl (Clayton)

19a. Informant's Name/Relationship (Type, Print)

Frank Angellatta-son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Pasadena MD 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Sunset Memorial Park

Date

07/03

20c. Location - City or Town, State

Cumberland MD

21. Signature of Funeral Service Licensee

James F. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home
Cumberland MD 21502

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. chronic renal failure

Due to (or as a consequence of):

b. Diabetes mellitus

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 year

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular disease with history of intracranial aneurysm. Hypothyroidism

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient3 ☒ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier

Stuart Jacobs MD

29c. License number

D 22423

29d. Date signed (Month, Day, Year)

July 1, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STUART JACOBS MD. 301 Hospital Drive, Glen Burnie, MD. 21061

31. Date filed (Month, Day, Year)

JUL 08 1997

32. Registrar's Signature

Judy...

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21244

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jeanne Deery Beck				2. Date of Death Month Day Year June 25 1997		3. Time of Death 3:00PM	
	4e. Facility Name (If not institution, give street and number) 556 Ferry Point Road				4b. City, Town, or Location of Death 21403		4c. County of Death United States	
Funeral Director	5. Social Security Number 212-76-0137		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 70 Yrs.		8. Date of Birth (Month, Day, Year) April 7 1927	
	9. Birthplace (State or Foreign Country) Delaware		10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Annapolis	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street end Number 556 Ferry Point Road		10f. Zip Code 21403		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 3		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales		16b. Kind of Business/Industry Childrens Retail/Clothing			
	17. Father's Name (First, Middle, Last) William A. Deery				18. Mother's Name (First, Middle, Maiden Surname) Bertha Stoores			
	19a. Informant's Name/Relationship (Type, Print) Dr. Edward Beck (Husband)				19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 556 Ferry Point Road Annapolis, Maryland 21403			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Crematory		Date 6/27/97		20c. Location - City or Town, State Brentwood, Maryland	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Head & neck cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street end Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Ann C. Morrey, M.D.				29c. License number D44465		29d. Date signed (Month, Day, Year) 06/25/97		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Ann C. Morrey, M.D., 900 Bertgate Rd, Annapolis, MD 21401								
31. Date filed (Month, Day, Year) JUL 01 1997				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21245

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DANIEL MAC BROWN				2. Date of Death Month Day Year JUNE 20 1997		3. Time of Death 12:50 pm	
	4a. Facility Name (If not institution, give street and number) CHESAPEAKE MANOR NURSING CENTER				4b. City, Town, or Location of Death ARNOLD		4c. County of Death ANNE ARUNDEL	
Funeral Director	5. Social Security Number 214-56-1019		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 47 Yrs.		8. Date of Birth (Month, Day, Year) JAN. 18 1950	
	10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location ANNAPOLIS		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th Collega (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PACKER		16b. Kind of Business/Industry UNITED MOVING & STORAGE	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates 1969-72		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
	14. Recce - American Indian, Black, White, etc. Specify: BLACK							
	17. Father's Name (First, Middle, Last) MACK A. BROWN				18. Mother's Name (First, Middle, Maiden Surname) SUSAN SIMMS			
	19a. Informant's Name/Relationship (Type, Print) MARY WATKINS (COUSIN)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1121 EASTPORT TERRACE ANNAPOLIS, MD. 21403			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) MARYLAND VETERAN CEMETERY		20c. Location - City or Town, State 6/30/97 CROWNSVILLE, MD.	
	21. Signature of Funeral Service Licenses Harry N. Reese				22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cerebral & Lung Due to (or as a consequence of): Acquired Immune Deficiency Syndrome Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Approximate Interval Between Onset and Death 3 Months 2 Years							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	23c. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				23d. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28b. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier William M. Attending Doctor				
29c. License number D21684				29d. Date signed (Month, Day, Year) 7-1-97				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CN-CYRIAC M.D. 8105 RITCHIE AVE, PASADENA, MD 21122								
31. Date filed (Month, Day, Year) JUL 02 1997				32. Registrar's Signature John Davidson				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23c show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

97 21246

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EVA S. BROWN				2. DATE OF DEATH MONTH JUNE DAY 27 YEAR 1997		3. TIME OF DEATH 6:45 A M	
4. SOCIAL SECURITY NUMBER 24652 0191		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) JULY 15, 1915	
8. BIRTHPLACE (State or Foreign Country) NORTH CAROLINA				9. COUNTY OF DEATH PRINCE GEORGES			
9a. FACILITY NAME (If not institution, give street and number) SOUTHERN MARYLAND HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH CLINTON			
10a. STATE Maryland		10b. COUNTY Prince George's County		10c. CITY, TOWN OR LOCATION Fort Washington		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 12707 Parkton Street				10f. ZIP CODE 20744		10g. CITIZEN OF WHAT COUNTRY? United States of America	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Domestic		16b. KIND OF BUSINESS/INDUSTRY Private Homes			
17. FATHER'S NAME (First, Middle, Last) Oscar Strickland				18. MOTHER'S NAME (First, Middle, Maiden Surname) Harriett Strickland			
19a. INFORMANT'S NAME (Type/Print) Coy Cooper / Son				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10309 Conover Drive, Silver Spring, Maryland 20902			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Strickland Family Cemetery		DATE 6/29 1997		20c. LOCATION — City or Town, State Spring Hope, North Carolina	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Donald A. Carson		#M00690		22. NAME AND ADDRESS OF FACILITY William Toney's Funeral Home (P.O. Box 430) 516 Poplar Street, Spring Hope, North Carolina 27882			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate interval between Onset and Death YEARS	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. GANGRENE FOOT						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Philip Wisotzky MD.				29c. LICENSE NUMBER D18545		29d. DATE SIGNED (Month, Day, Year) JUNE 27, 1997	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Philip Wisotzky MD. 700 OLD LINE CENTER WILDORE MD.							
31. DATE FILED (Month, Day, Year) JUL 03 1997		32. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



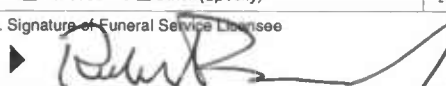
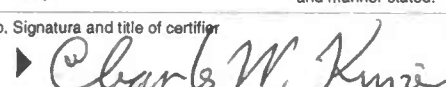
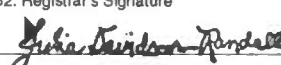
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21247

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Cecelia Jo Becker					2. Date of Death Month Day Year June 28, 1997			3. Time of Death 7:18 am												
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center					4b. City, Town, or Location of Death Annapolis			4c. County of Death Anne Arundel												
Funeral Director	5. Social Security Number 442-24-1332		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 9, 1925		9. Birthplace (State or Foreign Country) OK												
	Usual Residence of Decedent																				
10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Arnold				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
10e. Street and Number 808 Barrett Avenue			10f. Zip Code 21012			10g. Citizen of What Country? USA															
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White												
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) College			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Home															
17. Father's Name (First, Middle, Last) Willie Hooper					18. Mother's Name (First, Middle, Maiden Surname) Ethel Kirchoff																
19a. Informant's Name/Relationship (Type, Print) Donald E. Becker					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 808 Barrett Avenue, Arnold, MD 21012																
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veteran's Cem.			Date July 2, 1997		20c. Location - City or Town, State Crownsville, MD													
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy. Severna Park, MD 21146																
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <table border="0"> <tr> <td rowspan="4"> Immediata Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td rowspan="4"> { </td> <td>e. Acute inferior wall myocardial infarction Due to (or as a consequence of):</td> <td>2 hours</td> </tr> <tr> <td>b. Coronary arteriosclerosis Due to (or as a consequence of):</td> <td>unknown</td> </tr> <tr> <td>c. — Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d. — Due to (or as a consequence of):</td> <td></td> </tr> </table>										Immediata Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	{	e. Acute inferior wall myocardial infarction Due to (or as a consequence of):	2 hours	b. Coronary arteriosclerosis Due to (or as a consequence of):	unknown	c. — Due to (or as a consequence of):		d. — Due to (or as a consequence of):		Approximate Interval Between Onset and Death	
Immediata Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	{	e. Acute inferior wall myocardial infarction Due to (or as a consequence of):	2 hours																		
		b. Coronary arteriosclerosis Due to (or as a consequence of):	unknown																		
		c. — Due to (or as a consequence of):																			
		d. — Due to (or as a consequence of):																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive pulmonary disease Fever due to probable sepsis								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown													
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No																			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred												
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)														
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																					
29b. Signature and title of certifier 					29c. License number D05928		29d. Date signed (Month, Day, Year) June 28, 1997														
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Charles W. Kinzer, MD, 2003 Medical Pkwy #100, Annapolis, MD 21401																					
31. Date filed (Month, Day, Year) JUL 03 1997			32. Registrar's Signature 																		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

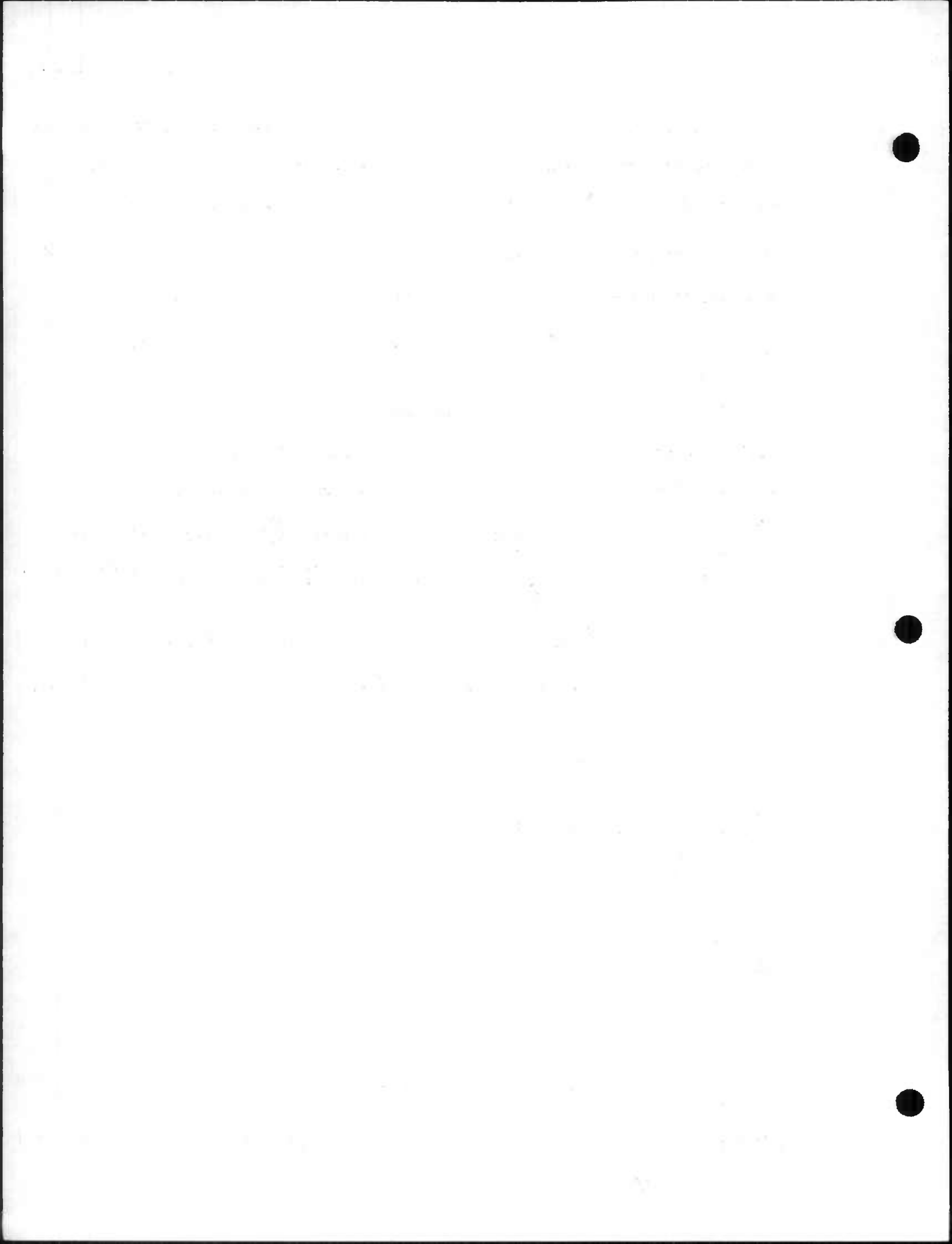
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21248

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Pauline W. Burke				2. Date of Death Month Day Year July 2, 1997		3. Time of Death 12:23 PM	
	4a. Facility Name (If not institution, give street and number) 4187 Solomons Island Road				4b. City, Town, or Location of Death Harwood		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 216-44-4165		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) July 11, 1911	
	9. Birthplace (State or Foreign Country) Ohio		10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Harwood	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 4187 Solomons Island Road		10f. Zip Code 20776		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrative Assistant		16b. Kind of Business/Industry Dep't. of Justice			
	17. Father's Name (First, Middle, Last) Wilbur Willoughby				18. Mother's Name (First, Middle, Maiden Surname) Pearl Alspach			
	19a. Informant's Name/Relationship (Type, Print) Lynn W. Headley/ Niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 700 Bancroft Ave. Colonial Beach, Virginia 22443			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lakemont Mem'l. Gardens 7-7-97		20c. Location - City or Town, State Davidsonville, Maryland			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, Md. 21037			
	23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. CARDIO PULMONARY ARREST Due to (or as a consequence of): b. GALLBLADDER CA Due to (or as a consequence of): c. HTN Due to (or as a consequence of): d. CHF							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ATRIAL FIBRILLATION OGILVIE'S SYNDROME							
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
Medical Certification: To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier 				29c. License number 20050741		29d. Date signed (Month, Day, Year) 7/2/97 W	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERIC A. SAUTTER, MD 139 OLD SEABOARD RD / ANNAPOLIS MD 21401							
	31. Date filed (Month, Day, Year) JUL 07 1997				32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

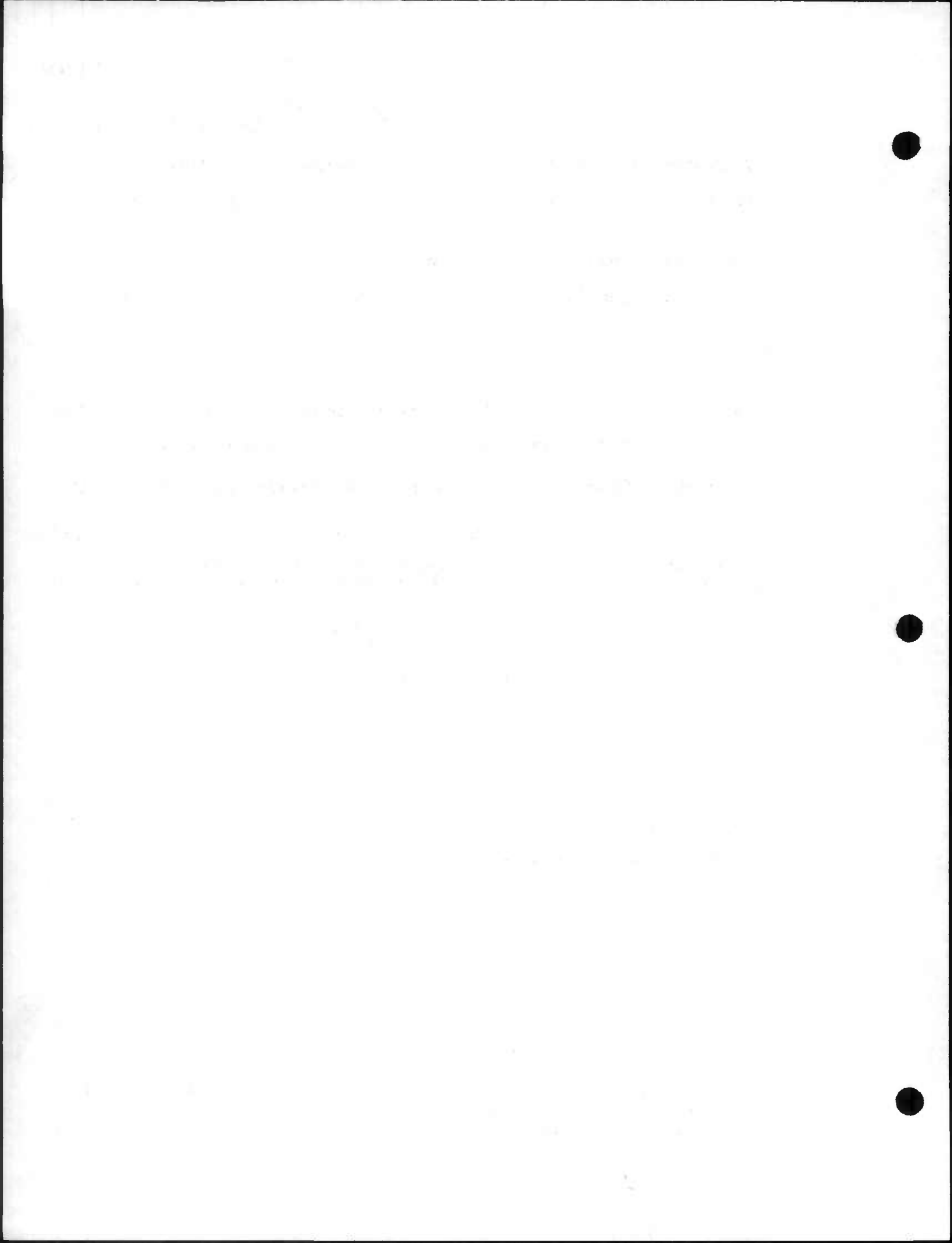
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21249

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FLORENCE ROSE BEDINGFIELD				2. Date of Death Month Day Year JULY 1, 1997				3. Time of Death 11:15 AM	
	4a. Facility Name (If not institution, give street and number) 5537 HUCKLEBERRY DRIVE				4b. City, Town, or Location of Death BRYANTOWN				4c. County of Death CHARLES	
Funeral Director	5. Social Security Number 578-05-8766		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) MARCH 3, 1913		9. Birthplace (State or Foreign Country) PENNSYLVANIA	
	Usual Residence of Decedent				10a. State MARYLAND		10b. County CHARLES		10c. City, Town or Location BRYANTOWN	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 7064 OLD LEONARDTOWN ROAD		10f. Zip Code 20617		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) HOMEMAKER				18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) OWN HOME		16b. Kind of Business/Industry OWN HOME			
	17. Father's Name (First, Middle, Last) DANIEL HAROLD BURKE				18. Mother's Name (First, Middle, Maiden Surname) FLORENCE ELEANOR DIXON					
	19a. Informant's Name/Relationship (Type, Print) JOAN B. CROWN / DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5537 HUCKLEBERRY DRIVE, BRYANTOWN, MARYLAND 20617					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MARYLAND VETERANS' CEMETERY 7/7/1997 CHELTENHAM, MARYLAND		20c. Location - City or Town, State					
	21. Signature of Funeral Service Licensee MARK G. BROHAWN M00053				22. Name and Address of Facility THE HUNTT FUNERAL HOME, INC., P.O. BOX 156, WALDORF, MARYLAND 20604-0156					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Congestive Heart Failure Due to (or as a consequence of): Advanced Atherosclerosis Due to (or as a consequence of): Myocardial Infarction 1995 Due to (or as a consequence of):				Approximate Interval Between Onset and Death x months x years					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier George H. Watnen				29c. License number D20629		
29d. Date signed (Month, Day, Year) 7/3/97				30. Name and address of person who completed cause of death (Item 23e) (Type, Print) GEORGE H. WATNEN, MD, 11345 PEMBROOKE SQ. #103, WALDORF, MD 20603						
31. Date filed (Month, Day, Year) JUL 03 1997				32. Registrar's Signature Julia H. Russell						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21250

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SHIRLEY MAXINE BANEY		2. Date of Death Month JUNE Day 30 Year 1997		3. Time of Death 9:45 PM
	4a. Facility Name (If not institution, give street and number) ST. MARY'S NURSING CENTER		4b. City, Town, or Location of Death LEONARDTOWN		4c. County of Death ST. MARY'S
Funeral Director	5. Social Security Number 205-12-9256	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) AUGUST 3, 1924		9. Birthplace (State or Foreign Country) PENNSYLVANIA		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State MARYLAND	10b. County ST. MARY'S	10c. City, Town or Location MECHANICSVILLE		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 29831 SKY VIEW DRIVE		10f. Zip Code 20659		10g. Citizen of What Country? U.S.A.
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) HOUSEWIFE		
	16. Kind of Business/Industry OWN HOME		17. Father's Name (First, Middle, Last) CLARENCE BRADY, SR.		
	18. Mother's Name (First, Middle, Maiden Surname) BERTHA PIERCE		19a. Informant's Name/Relationship (Type, Print) JUDITH A. TOOLE / DAUGHTER		
	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29841 SKY VIEW DRIVE, MECHANICSVILLE, MD 20659		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		
	20b. Place of Disposition (Name of cemetery, crematory or other place) TRINITY MEMORIAL GARDENS		20c. Location - City or Town, State 7/3/1997 WALDORF, MARYLAND		
	21. Signature of Funeral Service Licensee JPK MARK G. BROHAWN M00053		22. Name and Address of Facility THE HUNTT FUNERAL HOME, INC. P.O. BOX 156, WALDORF, MARYLAND 20604		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) a. chronic obstructive pulmonary disease Due to (or as a consequence of): b. Lung Lymphoma Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				Ten years about three years
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		
	28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)
	29a. Certifier (Check only one) XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier (DR. M. A. Rahman, MD)		29c. License number D50044		29d. Date signed (Month, Day, Year) JULY 1, 1997
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOHAMMAD ANISURM RAHMAN, M.D., 24035 THREE NOTCH RD. (RT.235), LEONARDTOWN, MD 20650					
31. Date filed (Month, Day, Year) JUL 03 1997		32. Registrar's Signature Julia Davidson-Rodall			

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland permit.

Division of Vital Records, P.O. Box 68760,

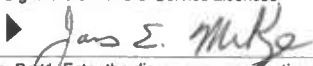
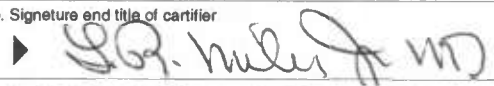
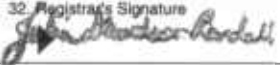
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

21251

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Clifton Jerome Broadwater						2. Date of Death Month June Day 29 Year 1997		3. Time of Death 5:00 A.M.	
	4a. Facility Name (If not institution, give street and number) Egle Nursing Home						4b. City, Town, or Location of Death Lonaconing		4c. County of Death Allegany	
Funeral Director	5. Social Security Number 217-10-4768		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) May 26, 1911		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
10a. State Maryland			10b. County Allegany			10c. City, Town or Location Lonaconing			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 3 Dudley Street						10f. Zip Code 21539		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Labor			16b. Kind of Business/Industry Spinning Dept.	
17. Father's Name (First, Middle, Last) J. Nelson Broadwater						18. Mother's Name (First, Middle, Maiden Surname) Virginia Broadwater				
19a. Informant's Name/Relationship (Type, Print) Sandra D. Grandstaff						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 39 E. Railroad St., Lonaconing, Md. 21539				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Laurel Hill Cemetery			Date July 2, 1997		20c. Location - City or Town, State Moscow Mills, Md.	
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Eichhorn-McKenzie Funeral Home Lonaconing, Md. 21539				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a. Congestive Heart Failure Due to (or as a consequence of):										1 year
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. General Atherosclerosis Due to (or as a consequence of):										10 years
c. _____ Due to (or as a consequence of):										
d. _____ Due to (or as a consequence of):										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus Dementia										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29b. Signature and title of certifier 		29c. License number DS7004		
29d. Date signed (Month, Day, Year) 06/29/97						30. Name and address of person who completed cause of death (Item 23e) (Type, Print) L.R. MILES, JR., M.D. 57 JACKSON ST. LONA CONING MD 21539				
31. Date filed (Month, Day, Year) JUL 01 1997						32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

6
MS

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21252

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Adolph E. Buescher, Jr.				2. Date of Death Month Day Year July 1 1997		3. Time of Death 6:30 am	
	4a. Facility Name (If not institution, give street and number) 14 Papermill Street				4b. City, Town, or Location of Death Easton		4c. County of Death Talbot	
Funeral Director	5. Social Security Number 498-12-7356	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 6, 1922		9. Birthplace (State or Foreign Country) Missouri
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Talbot	10c. City, Town or Location Easton			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10a. Street and Number 14 Papermill Street			10f. Zip Code 21601		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineer		16b. Kind of Business/Industry Missile & Space			
	17. Father's Name (First, Middle, Last) Adolph E. Buescher, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Eugenie Stroh			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Ruth L. Buescher/Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Papermill Street, Easton, MD 21601				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Oxford Cemetery		Date 7/5		20c. Location - City or Town, State Oxford, MD 21654	
	21. Signature of Funeral Service Licensee JOHN R. MERCERON CFSP			22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home 200 S. Harrison St., Easton, MD 21601				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Adenocarcinoma of the esophagus, metastatic Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Approximate Interval Between Onset and Death 3 years							
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		28e. Place of injury - At home, farm, street, tectory, office building, etc. (Specify)		28d. Describe how injury occurred				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier David A. Stout, M.D.		29c. License number D06804		29d. Date signed (Month, Day, Year) July, 2, 1997		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David A. Stout, M.D. Memorial Hosp. 219 S. Washington St., Easton, MD 21601								
State Registrar	31. Date filed (Month, Day, Year) JUL - 2 1997		32. Registrar's Signature [Signature]					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

97-3438-047

B.K.S.

Cornellia Butler

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21253

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Cornelia Daisy Butler				2. Date of Death Month June Day 22 , Year 1997		3. Time of Death 1530 PM	
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 213-41-8864		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 3 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 01-17-94	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent 10e. State Maryland 10b. County Worcester 10c. City, Town or Location Pocomoke City 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10f. Zip Code 21851		10g. Citizen of What Country? USA	
To Be Completed by Funeral Director	11. Marital Status <input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) None		16b. Kind of Business/Industry None			
	17. Father's Name (First, Middle, Last) Cornelius Butler				18. Mother's Name (First, Middle, Maiden Surname) Poinsettia Dennis			
	19a. Informant's Name/Relationship (Type, Print) Poinsettia Dennis (mother)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 612 Cedar Street, Pocomoke City, Maryland 21851			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cottage Grove Cemetery		Data 6/28/97		20c. Location - City or Town, State Pocomoke City, Maryland	
	21. Signature of Funeral Service Licensee <i>John St. Prince</i>				22. Name and Address of Facility Bennie Smith Funeral Home P.O. Box 1687, Easton, Maryland 21601			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Multiple Injuries</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 6/22/97		28b. Time of Injury 1237 P M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) street		28d. Describe how injury occurred pedestrian struck by car					
	28f. Location (Street and Number or Rural Route Number, City or Town, State) 612 Cedar St Pocomoke City, Md							
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>Dennis J. Chute, MD</i>		29c. License number O.C.M.E.	
	29d. Data signed (Month, Day, Year) 6-23-97				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute MD 111 Penn St. Baltimore, Md. 21201			
	31. Date filed (Month, Day, Year) JUN 30 1997				32. Registrar's Signature <i>John St. Prince</i>			
	32. Registrar's Signature							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21254

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM THOMAS BELL				2. Date of Death Month Day Year JUNE 23, 1997				3. Time of Death 0358	
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY				4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 219-07-0366		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Data of Birth (Month, Day, Year) 3-21-1919		9. Birthplace (State or Foreign Country) MARION ST. MD.	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD.		10b. County WICOMICO		10c. City, Town or Location SALISBURY				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 1525 ESQUIRE DRIVE				10f. Zip Code 21801		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: AFRO-AMERICAN			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4or 5+) 9th				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER		16b. Kind of Business/Industry RET. CUSTODIAN/WATERMAN			
	17. Father's Name (First, Middle, Last) FRANK BORDEN				18. Mother's Name (First, Middle, Maiden Surname) MARY EMILY BELL					
	19a. Informant's Name/Relationship (Type, Print) NORMA B. BELL /WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ADDRESS SAME AS ABOVE					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) SPRINGHILL MEMORY GARDEN		Date 6-28		20c. Location - City or Town, State HEBRON, MD.			
	21. Signature of Funeral Service Licensee <i>Louetta B. Colley</i>				22. Name and Address of Facility JOLLEY MEMORIAL CHAPEL 1213 JERSEY ROAD; SALISBURY, MD. 21801					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Acute myocardial infarction and</i> Due to (or as a consequence of): b. <i>cardiogenic shock</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>History Congestive Heart Failure</i>									
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined										
28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>[Signature]</i> 29c. License number D-39813 29d. Date signed (Month, Day, Year) 6/23/97										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>MARKINS 1104 Westbury Drive SALIS MD 21804</i>										
31. Date filed (Month, Day, Year) JUN 25 1997 32. Registrar's Signature <i>John Davidson Randall</i>										

WILLIAM BELL 219-07-0366

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21255

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DAVID ANGUS BIONDI				2. Date of Death Month Day Year June 19 1997		3. Time of Death 1734	
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 579-36-6800	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) February 14, 1916		9. Birthplace (State or Foreign Country) Pennsylvania
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Wicomico	10c. City, Town or Location Salisbury			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 722 Camden Ave.			10f. Zip Code 21801		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) -			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Consultant			16b. Kind of Business/Industry Government Banking	
	17. Father's Name (First, Middle, Last) William A. Biondi			18. Mother's Name (First, Middle, Maiden Surname) Jeanette Dyer				
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Helen Biondi/Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 722 Camden Ave., Salisbury, MD 21801				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory		Data 6/23/97		20c. Location - City or Town, State Salisbury, MD	
	21. Signature of Funeral Service Licensee David H. Thompson MO 1051			22. Name and Address of Facility Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Lung Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death months
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Failure Coronary Artery Disease							23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Jeffrey Etherington		29c. License number D36783		29d. Date signed (Month, Day, Year) 6/19/97		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeffrey Etherington / MD PRMC Salisbury MD 21801								
31. Date filed (Month, Day, Year) JUN 23 1997		32. Registrar's Signature John Davidson Randall						

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21256

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CATHERINE MARY CLARK				2. Date of Death Month JUNE Day 27 , Year 1997		3. Time of Death 9:57 AM		
	4a. Facility Name (If not institution, give street and number) 7885 GORDON COURT APT 571				4b. City, Town, or Location of Death GLEN BURNIE		4c. County of Death ANNE ARUNDEL		
Funeral Director	5. Social Security Number 217.03.0481	6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) APRIL 8, 1914		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MARYLAND	10b. County ANNE ARUNDEL		10c. City, Town or Location GLEN BURNIE			10d. Inside City Limits 1 Yes 2 No		
	10e. Street and Number 7885 GORDON COURT			10f. Zip Code 21060		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) UNKNOWN College (1-4 or 5+) UNKNOWN		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER			16b. Kind of Business/Industry OWN HOME			
	17. Father's Name (First, Middle, Last) GEORGE O. REUS				18. Mother's Name (First, Middle, Maiden Surname) DOROTHY M. ADLER				
To Be Completed by Physician/Medical Examiner	19e. Informant's Name/Relationship (Type, Print) SEYMOUR A. EWING (FRIEND)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 630 S. HANOVER ST., CARLISLE, PA 17013				
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CUMBERLAND VALLEY MEM. GARDENS		Date 7/1/97		20c. Location - City or Town, State WEST PENNSBORO TWP. CUMBERLAND COUNTY, PA		
	21. Signature of Funeral Service Licensee <i>Michael C. Gaffian</i>				22. Name and Address of Facility SINGLETON FUNERAL HOME 1 SECOND AVE. S.W. GLEN BURNIE, MARYLAND 21061				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Myocardial infarction Due to (or as a consequence of): b. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death Unknown	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown	
25. Was case referred to medical examiner? 1 Yes 2 No				26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)					
27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury et Work? 1 Yes 2 No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>B. Bercovitz MD</i>		29c. License number 036033		29d. Date signed (Month, Day, Year) 6 27 97	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) B BERCOVITZ 8028 RITCHIE HIGHWAY PASADENA MD 21122									
31. Date filed (Month, Day, Year) JUL 01 1997				32. Registrar's Signature <i>Julia Gordon-Randall</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21257

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Steven Howard Chiodi						2. Date of Death Month Day Year JUN 30 97		3. Time of Death 1319	
	4a. Facility Name (If not institution, give street and number) 155 Monticello Ave						4b. City, Town, or Location of Death Annapolis		4c. County of Death AA	
Funeral Director	5. Social Security Number 468-80-3456		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 31 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) March 30 1966		9. Birthplace (State or Foreign Country) Minnesota		10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Annapolis	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 155 Monticello Avenue		10f. Zip Code 21401		10g. Citizen of What Country? United States				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 Collega (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Executive		16b. Kind of Business/Industry Automobile Manufacturing		17. Father's Name (First, Middle, Last) Richard Chiodi		18. Mother's Name (First, Middle, Maiden Surname) Carole Cole		
19a. Informant's Name/Relationship (Type, Print) William M. Carter (Father-In-Law)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 39 Southgate Ave. Annapolis, Maryland 21401		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Crematory July 2, 1997 Brentwood, Maryland		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Shotgun Wound Head Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death UNK				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 6/30/97		28b. Time of Injury UNK		
28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Shot SELF		28e. Location (Street and Number or Rural Route Number, City or Town, State) Annapolis, MD		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier 		29c. License number D06054		29d. Date signed (Month, Day, Year) 6/30/97		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William R. Jones, MD 695 America 21035				
31. Date filed (Month, Day, Year) JUL 03 1997		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

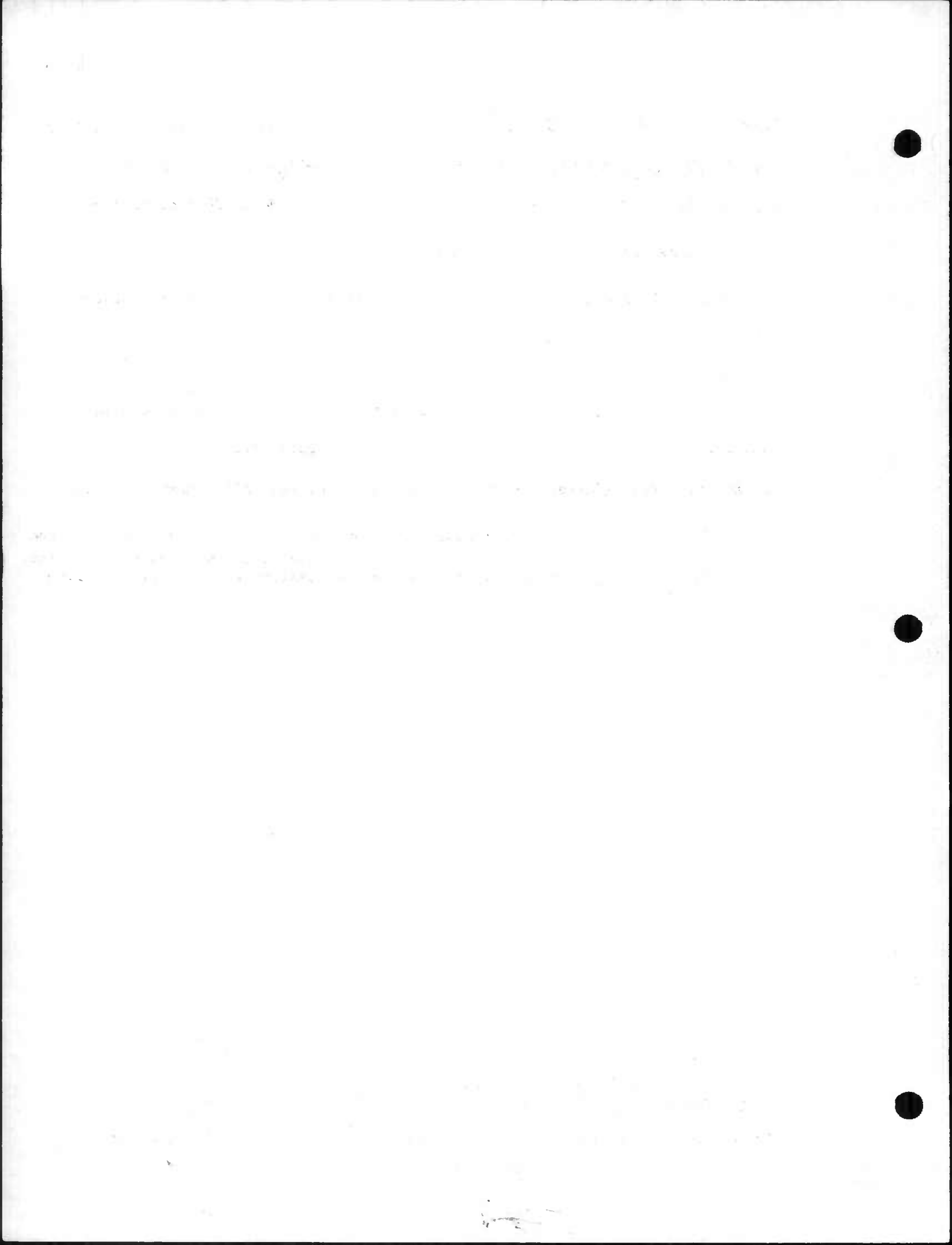
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21258

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PHILLIP G. COLE				2. Date of Death Month JULY Day 2, Year 1997		3. Time of Death 5:45 AM						
	4a. Facility Name (If not institution, give street and number) PHYSICIANS MEMORIAL HOSPITAL				4b. City, Town, or Location of Death LAPLATA		4c. County of Death CHARLES						
Funeral Director	5. Social Security Number 218-14-3405		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 92 Yrs.		8. Date of Birth (Month, Day, Year) DEC. 24, 1904		9. Birthplace (State or Foreign Country) MARYLAND				
	Usual Residence of Decedent												
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County CHARLES		10c. City, Town or Location BEL ALTON				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	10e. Street and Number 8150 BEL ALTON NEWTOWN ROAD				10f. Zip Code 20611		10g. Citizen of What Country? UNITED STATES						
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABOR			16b. Kind of Business/Industry PRIVATE					
	17. Father's Name (First, Middle, Last) DAN COLE				18. Mother's Name (First, Middle, Maiden Surname) ANNIE GROSS COLE								
	19a. Informant's Name/Relationship (Type, Print) DESALES COLE / BROTHER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20611 P.O. BOX 162 BEL ALTON NEWTOWN RD. BEL ALTON, MD								
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) SACRED HEART CHURCH CEMETERY		Data 7/7/97		20c. Location - City or Town, State LA PLATA, MARYLAND						
	21. Signature of Funeral Service Licensee LEON THORNTON				22. Name and Address of Facility THORNTON FUNERAL HOME 3439 LIVINGSTON ROAD INDIAN HEAD, MD 20640								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):										Approximate Interval Between Onset and Death + 7 wk		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier GEORGE WATHEN M.D.				29c. License number D-20629		29d. Date signed (Month, Day, Year) 7/2/97					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEORGE WATHEN M.D. 11345 PEMBROOKE SQUARE SUITE 103 WALDORF MD. 20603													
31. Date filed (Month, Day, Year) JUL 03 1997		32. Registrar's Signature 											

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21259

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Darlene M. Carter

2. Date of Death

Month Day Year
June 27, 1997

3. Time of Death

6:38 am

4a. Facility Name (If not institution, give street and number)

Memorial Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral
Director

5. Social Security Number

299-52-2520

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

45

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
11-Dec-31

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

301 Baltimore Street

10f. Zip Code

21502-

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
10College (1-4 or 5+)
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nursing Assistant

16b. Kind of Business/Industry

Nursing

17. Father's Name (First, Middle, Last)

Robert Reger

18. Mother's Name (First, Middle, Maiden Surname)

Luella Simpson

19a. Informant's Name/Relationship (Type, Print)

Gary F. Carter Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15617 Mount Savage Road Mount Savag Maryland 21545-

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veteran's Cemetery at R

Date

01-Jul-97

20c. Location - City or Town, State

Cumberland, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Acute MI

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1hr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D 44712

29d. Date signed (Month, Day, Year)

7/1/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. N. McCullough, 921 Seton Drive, Suite C, Cumberland, MD 21502

31. Date filed (Month, Day, Year)

JUL 01 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

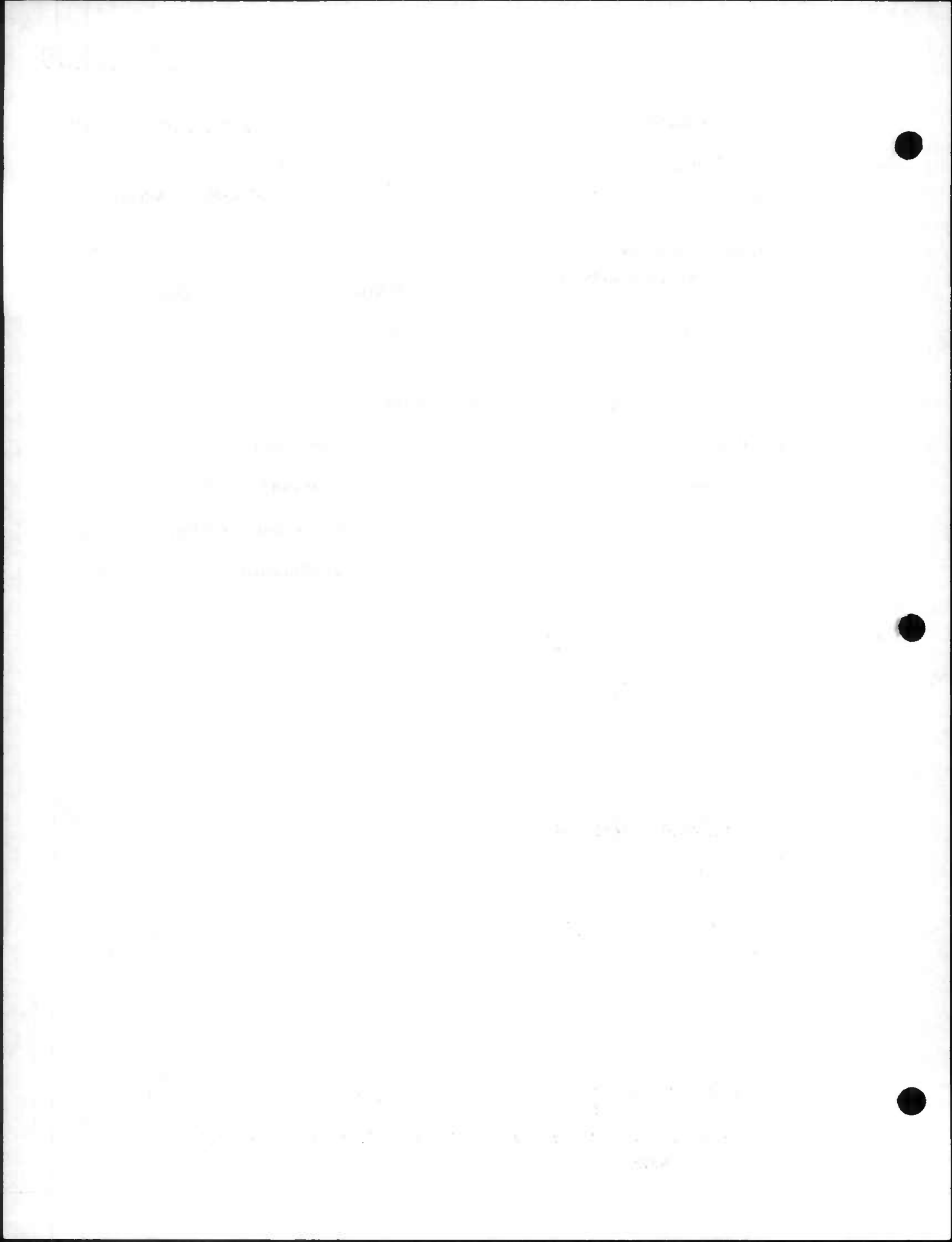
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21260

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EDWARD RICHARD COSGROVE

2. Date of Death

Month Day Year
June 30, 1997

3. Time of Death

5:18 am

4a. Facility Name (If not institution, give street and number)

Memorial Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral
Director

5. Social Security Number

318-24-2344

6. Sex

XX M 2□ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

APRIL 3 1925

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ALLEGANY

10c. City, Town or Location

CUMBERLAND

10d. Inside City Limits

1□ Yes XX□ No

10e. Street and Number

12009 KITE AVE (POTOMAC PARK)

10f. Zip Code

21502

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1□ Never Married 2X Married
3□ Widowed 4□ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

XX Yes 2□ No

If Yes, Give Year or Dates: WW11

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□ Yes 2X No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

COSGROVE CYCLE CO. PRESIDENT

16b. Kind of Business/Industry

CYCLES RETAIL

17. Father's Name (First, Middle, Last)

EDWARD A. COSGROVE

18. Mother's Name (First, Middle, Maiden Surname)

CATHERINE NEE

19a. Informant's Name/Relationship (Type, Print)

NANCY COSGROVE WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12009 KITE AVE CUMBERLAND MARYLAND 21502

20a. Method of Disposition

XX Burial 2□ Cremation 3□ Removal from State
4□ Donation 5□ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SUNSET CEMETERY JULY 3 1997

Date

20c. Location - City or Town, State

CUMBERLAND MARYLAND

21. Signature of Funeral Service Licensee

Dale L. Merritt

22. Name and Address of Facility

MERRITT-ADAMS FUNERAL HOME

404 DECATUR STREET CUMBERLAND MARYLAND

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

CARDIOPULMONARY ARREST

e.

Due to (or as a consequence of):

b.

MASSIVE MI

Due to (or as a consequence of):

c.

SEVERE INTERSTITIAL FIBROSIS 02 DEPENDANT

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Less than one hour

Less than one hour

Less than one year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1□ Yes 2X No 3□ Probably 4□ Unknown

24a. Was an autopsy performed?

1□ Yes 2X No

24b. Were autopsy findings available prior to completion of cause of death?

1□ Yes 2□ No

25. Was case referred to medical examiner?

1□ Yes 2X No

Hospital:

1X Inpatient

2□ ER/Outpatient

3□ DOA

26. Place of Death (Check only one)

Other:

4□ Nursing Home

5□ Residence

6□ Other (Specify)

27. Manner of Death

1X Natural 5□ Pending investigation
2□ Accident 6□ Could not be determined
3□ Suicide
4□ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1□ Yes 2□ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. T. Williams

29c. License number

D 16041

29d. Date signed (Month, Day, Year)

June 30, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. T. Williams, Memorial Hospital Medical Bldg., Cumberland, MD 21502

31. Date filed (Month, Day, Year)

JUL 02 1997

32. Registrar's Signature

John Anderson-Rodell

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

EDWARD COSGROVE

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21261

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Katie Mae Calhoun				2. Date of Death Month JUNE Day 30 Year 1997		3. Time of Death 10:20AM	
	4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital				4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany	
Funeral Director	5. Social Security Number 213-22-3650	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month Day Year FEB 10, 1927		9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent							
10a. State MD		10b. County Allegany		10c. City, Town or Location Rawlings			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 21016 McMullen Highway				10f. Zip Code 21557		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home	
17. Father's Name (First, Middle, Last) Benjamin Dorsey				18. Mother's Name (First, Middle, Maiden Surname) Katie (MacMullan)				
19a. Informant's Name/Relationship (Type, Print) Sandra Cline-daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12613 Wilson Lane Cumberland MD 21502				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Restlawn Memorial Gardens		Date 07/03		20c. Location - City or Town, State LaVale MD
21. Signature of Funeral Service Licensee James F. Scarpelli				22. Name and Address of Facility Scarpelli Funeral Home Cumberland MD 21502				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Metastatic Oat Cell Carcinoma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death 6 WKS
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart failure D, Abeto mellitus								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier G. Wagoner MD				29c. License number D22181		29d. Date signed (Month, Day, Year) July 1-97		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gary Wagoner, M.D. Bishop Walsh Drive Cumberland MD 21502								
31. Date filed (Month, Day, Year) JUL 03 1997								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21262

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>EMERY EMERA S. CULVER</i>				2. Date of Death Month Day Year JUNE 16, 1997		3. Time of Death 6:37 P	
	4e. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 222-14-1044		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 41 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 26, 1926	
	9. Birthplace (State or Foreign Country) DE.		10a. State De.		10b. County Sussex		10c. City, Town or Location Laurel	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number Rt. 3 Box 208C		10f. Zip Code 19956		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer		16b. Kind of Business/Industry Poultry			
	17. Father's Name (First, Middle, Last) Ray Culver				18. Mother's Name (First, Middle, Maiden Surname) Eva Hitchens Culver			
	19a. Informant's Name/Relationship (Type, Print) Betty E. Culver, Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 3 Box 208C Laurel, De. 19956			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Pleasant Cemetery		20c. Location - City or Town, State Laurel, De.		20d. Date 6-21-97	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Short Funeral Home, Inc. 700 West St. Laurel, De. 19956			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>Intracerebral Hemorrhage</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
State Registrar	29b. Signature and Title of Certifier <i>Ray L. Ham MD</i>				29c. License number RES-000		29d. Date signed (Month, Day, Year) June Sixteenth 1997	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Raymond I. Ham 600 North White Street Baltimore, Maryland</i>							
31. Date filed (Month, Day, Year) JUN 24 1997		32. Registrar's Signature <i>J. Davidson Randall</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

97 21263

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mildred Clouser				2. Date of Death June 27 1997		3. Time of Death 1:45 PM	
	4a. Facility Name (If not institution, give street and number) Salisbury Center: Genesis ElderCare				4b. City, Town, or Location of Death Salisbury, MD		4c. County of Death Wicomico	
Funeral Director	5. Social Security Number 222-01-8630		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 27, 1915	
	9. Birthplace (State or Foreign Country) Virginia		10a. State MD		10b. County Wicomico		10c. City, Town or Location Salisbury	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 300 Lemmon Hill Lane		10f. Zip Code 21801		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Home			
	17. Father's Name (First, Middle, Last) Alfred Baker				18. Mother's Name (First, Middle, Maiden Surname) Lola Tatum Baker			
	19a. Informant's Name/Relationship (Type, Print) Paul Clouser/ Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 600 Pelham Drive Waynesboro, VA 22980			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Stephens Cemetery		20c. Location - City or Town, State 6-30-97 Delmar, Delaware			
	21. Signature of Funeral Service Licensee <i>Maely Short-Hannigan</i>				22. Name and Address of Facility Short Funeral Home, Inc. 13 E. Grove St. Delmar, DE 19940			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Renal failure</i> Due to (or as a consequence of): <i>myocardial heart failure</i> Due to (or as a consequence of): <i>Atherosclerosis</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Approximate Interval Between Onset and Death <i>weeks</i> <i>weeks</i> <i>years</i>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier <i>William H. Robins</i>				29c. License number 029749		29d. Date signed (Month, Day, Year) 6/27/97	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William H. Robins, M.D. 1104 Healthway Dr., Salisbury, MD 21804							
31. Date filed (Month, Day, Year) JUN 30 1997				32. Registrar's Signature <i>John Davidson-Randall</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

97 21264

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George Evans Duvall				2. Date of Death Month Day Year July 01 1997				3. Time of Death 4:45AM	
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center				4b. City, Town, or Location of Death Annapolis				4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 212-30-3586		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) May 18 1910		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent				10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Annapolis	
To Be Completed by Funeral Director	10e. Street and Number 1007 Moss Haven Court				10f. Zip Code 21403		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Civilian Employee		16b. Kind of Business/Industry United States Naval Academy					
	17. Father's Name (First, Middle, Last) Robert Lee Duvall				18. Mother's Name (First, Middle, Maiden Surname) Mary Josephine Moss					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Frances S. Duvall (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1007 Moss Haven Court Annapolis, Maryland 21403					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Crematory		Date July 2, 1997		20c. Location - City or Town, State Brentwood, Maryland			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebellar and Subarachnoid Bleed Due to (or as a consequence of): b. Chronic Anticoagulation Due to (or as a consequence of): c. Thrombocytopenia Due to (or as a consequence of): d. Chronic Atrial Fibrillation Approximate Interval Between Onset and Death 6 hours 1 year 1.5 years 1 year									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Smoking Recent Left Hip Fracture							23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D32654		29d. Date signed (Month, Day, Year) July 1, 1997				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John P. Serlemitsos 1509 Ritchie Highway, Arnold, MD 21012										
31. Date filed (Month, Day, Year) JUL 03 1997		32. Registrar's Signature 								

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State of Maryland / Department of Health and Mental Hygiene

97 21265

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Raymond W. Dixon				2. Date of Death Month June Day 25 Year 1997		3. Time of Death approx 1:28 PM	
	4e. Facility Name (If not institution, give street and number) 201 St. Mark Way, Apt. #206				4b. City, Town, or Location of Death Westminster		4c. County of Death Carroll	
Funeral Director	5. Social Security Number 213-05-2072		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 7, 1915	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Carroll		10c. City, Town or Location Westminster	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 201 St. Mark Way, Apt. #206		10f. Zip Code 21158	
	10g. Citizen of What Country? United States				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: white		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (14 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) accountant				16b. Kind of Business/Industry accounting			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Raymond W. Dixon				18. Mother's Name (First, Middle, Maiden Surname) Aimee Wilson			
	19a. Informant's Name/Relationship (Type, Print) Helen W. Dixon, wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 St. Mark Way, Apt. #206, Westminster, MD 21158			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) West Liberty Cemetery		20c. Location - City or Town, State White Hall, MD	
	21. Signature of Funeral Service Licensee Katherine Fritz - Switzer				22. Name and Address of Funeral Home Proctor Funeral Home & Chapel 412 Washington Rd., Westminster, MD			
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Recurrent lymphoma - Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):						Approximate Interval Between Onset and Death 5 yrs	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		28g. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29b. Signature and title of certifier [Signature]	
	29c. License number 037949						29d. Date signed (Month, Day, Year) June 26th 1997	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Alexander Bojdaschewskyi, 1425 Liberty Rd., Sykesville, MD 21784						31. Data filed (Month, Day, Year) JUN 27 1997	
	32. Registrar's Signature [Signature]							

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State of Maryland / Department of Health and Mental Hygiene

97 21266

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Grace CATHERINE Dunn		2. Date of Death Month Day Year June 20, 1997		3. Time of Death 5:00 AM	
	4a. Facility Name (If not institution, give street and number) Salisbury Center: Genesis Eldercare		4b. City, Town, or Location of Death Salisbury, MD		4c. County of Death Wicomico	
Funeral Director	5. Social Security Number 214-10-8014	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) August 8, 1908		9. Birthplace (State or Foreign Country) Maryland			
To Be Completed by Funeral Director	10a. State Maryland		10b. County Wicomico		10c. City, Town or Location Salisbury	
	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
	10e. Street and Number 822 E. Isabella Street		10f. Zip Code 21801		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: White					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) -		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seamstress		16b. Kind of Business/Industry Shirt Factory	
	17. Father's Name (First, Middle, Last) George A. Whayland		18. Mother's Name (First, Middle, Maiden Surname) Mary Green			
	19a. Informant's Name/Relationship (Type, Print) Sharon L. Warren/Great Niece		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32716 Mt. Olive Rd., Salisbury, MD 21804			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parsons Cemetery		20c. Location - City or Town, State 6/24/97 Salisbury, MD	
	21. Signature of Funeral Service Licensee David H. Thompson		22. Name and Address of Facility Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. BRADY CARDIA AND HYPOTENSION Due to (or as a consequence of): b. SUSPECT 2° HEART BLOCK Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 6 cant cell arteriosclerosis				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
State Registrar	29b. Signature and title of certifier Michael R. Atkins, M.D.		29c. License number D 39813		29d. Date signed (Month, Day, Year) 6/20/97	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael R. Atkins, M.D. 1104 Healthway Dr., Salisbury, MD 21804					
	31. Date filed (Month, Day, Year) JUN 23 1997		32. Registrar's Signature John Davidson Randall			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21267

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Nancy Eccles				2. Date of Death Month June Day 29 Year 1997		3. Time of Death 02:40		
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death None		
Funeral Director	5. Social Security Number 231 58 9313		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 50 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 12/01/1946	9. Birthplace (State or Foreign Country) Virginia	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MD	10b. County Anne Arundel		10c. City, Town or Location Annapolis			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 1327 Bay Head Road				10f. Zip Code 21401		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) President/CEO				16b. Kind of Business/Industry Retail Firearms Store		
	17. Father's Name (First, Middle, Last) Robert Lee Bryan				18. Mother's Name (First, Middle, Maiden Surname) Marie Hamilton				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) David Eccles (Husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1327 Bay Head Road/Annapolis MD 21401				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date 6/30		20c. Location - City or Town, State Alexandria VA		
	21. Signature of Funeral Service Licensee Melanie Wilkins				22. Name and Address of Facility Advent Funeral & Cremation Services, Inc. Annapolis MD 21401				
	23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. Sub Arachnoid hemorrhage Due to (or as a consequence of):</p> <p>b. Intra Cerebral Aneurysm Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> </div> <div style="width: 35%;"> <p>Approximate Interval Between Onset and Death</p> <p>4 days</p> <p>5 days</p> </div> </div>								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
							24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier [Signature]				29c. License number P09131		29d. Date signed (Month, Day, Year) June 29, 1997			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Keith A. Harrison, 600 North Wolfe Street, Baltimore Maryland 21287									
31. Date filed (Month, Day, Year) JUL 02 1997		32. Registrar's Signature [Signature]							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21268

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) VIANNA B. ESTEP				2. Date of Death Month JUNE Day 27 Year 1997		3. Time of Death 3:35 PM	
	4a. Facility Name (If not institution, give street and number) 5825 Lakeview Drive				4b. City, Town, or Location of Death Sykesville		4c. County of Death Carroll	
Funeral Director	5. Social Security Number 220-36-7680		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 58 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 27, 1939	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Carroll		10c. City, Town or Location Sykesville	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 5825 Lakeview Drive		10f. Zip Code 21784		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Librarian		16b. Kind of Business/Industry Library				
17. Father's Name (First, Middle, Last) Arthur Long				18. Mother's Name (First, Middle, Maiden Surname) Vianna Mitchell				
19a. Informant's Name/Relationship (Type, Print) Mr. Howard M. Estep (Husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5825 Lakeview Drive Sykesville, MD 21784				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremation Serv.		20c. Location - City or Town, State 6/30/97 Hampstead, MD				
21. Signature of Funeral Service Licensee Brian A. Haight				22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL (Box 195) Sykesville, MD 21784 (410)-795-1400				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Glioblastoma Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Stephanie Linder MD				29c. License number D43909		29d. Date signed (Month, Day, Year) June 28, 1997		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephanie Linder 2801 Foster Ave Baltimore, MD 21224								
31. Date filed (Month, Day, Year) JUN 30 1997				32. Registrar's Signature Jane Anderson-Randall				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

NAME:

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21269

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Gene S. Edmonson

2. Date of Death

Month Day Year
June 28, 1997

3. Time of Death

12:15 P

4e. Facility Name (If not institution, give street and number)

Memorial Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral
Director

5. Social Security Number

233-40-9860

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 23, 1927

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

904 Glenwood Street

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1949-53

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Parking Garage Attendant

16b. Kind of Business/Industry

Parking Authority

17. Father's Name (First, Middle, Last)

Clinton Edmonson

18. Mother's Name (First, Middle, Maiden Surname)

Viola Spencer

19a. Informant's Name/Relationship (Type, Print)

Priscilla Montgomery/sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5906 South 81st Drive, Tampa, Fla. 33619

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rocky July

Veteran Cemetery-Gap

Date

July

1, 1997

20c. Location - City or Town, State

Cumberland, Md.

21. Signature of Funeral Service Licensee

Ernest A. Riley, Jr.

22. Name and Address of Facility

Leasure-Stein, Inc. 230 Baltimore Ave. Cumberland, Md. 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Acute respiratory failure

Due to (or as a consequence of):

June 24, 97

b. Non-Small cell carcinoma of lung

Due to (or as a consequence of):

Dec. 1992

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

D 23371

June 30 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Qamar Zaman, M.D. 625 Kent Ave. Cumberland, Md. 21502

31. Date filed (Month, Day, Year)

JUL 01 1997

32. Registrar's Signature

John A. Marshall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

GENE EDMONSON

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 97 21270
Certificate of Death Reg. No.

97 21270

6+1VA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21271

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) AUGUST HENRY FLERLAGE				2. Date of Death Month JULY Day 1 Year 1997		3. Time of Death 12:30 AM	
	4e. Facility Name (If not institution, give street and number) PHYSICIANS MEMORIAL HOSPITAL				4b. City, Town, or Location of Death LAPLATA		4c. County of Death CHARLES	
Funeral Director	5. Social Security Number 217-42-8089		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 51 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 15, 1945	
	9. Birthplace (State or Foreign Country) Maryland		10. Usual Residence of Decedent 10a. State Maryland 10b. County St. Mary's 10c. City, Town or Location Mechanicsville 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Funeral Director	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Worker	
	17. Father's Name (First, Middle, Last) Herman Aloysius Flerlage		18. Mother's Name (First, Middle, Maiden Surname) Gertrude Goldsmith		19a. Informant's Name/Relationship (Type, Print) Anthony G. Flerlage-Brother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14790 Country View Place, Waldorf, MD 20601	
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Mary's Cemetery		20c. Location - City or Town, State 7-7-97 Bryantown, MD		21. Signature of Funeral Service Licensee Shannon W. Ramirez M00798	
	22. Name and Address of Facility Hunt Funeral Home, Inc. P. O. Box 156, Waldorf, MD 20604-0156		23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e. Hepatic Encephalopathy Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. CIRRHOSIS OF LIVER		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Staphylococcal Septicemia		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	29b. Signature and title of certifier S. Ramirez		29c. License number D-20310		29d. Date signed (Month, Day, Year) 7/1/97		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SEETARAMAYYA NAGULA M.D. 11340 PEMBROKE SQUARE SUITE 202 WALDORF MD. 20603	
State Registrar	31. Date filed (Month, Day, Year) JUL 03 1997		32. Registrar's Signature John Davidson-Randall					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21272

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Walter W. Galenski

2. Date of Death

Month Day Year
June 28, 1997

3. Time of Death

7:00 A.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

4201 54th Street

4b. City, Town, or Location of Death

Bladensburg

4c. County of Death

Prince George's Co.

5. Social Security Number

016-12-8265

6. Sex

XXM 2□F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

February 24, 1914 Massachusetts

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bladensburg

10d. Inside City Limits

1X Yes 2□ No

10e. Street and Number

4201 54th Street

10f. Zip Code

20710

10g. Citizen of What Country?

United States
of America

11. Marital Status

1□ Never Married 2□ Married
3□ Widowed 4X Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1□ Yes 2X No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□ Yes 2X No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
10

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Owner/ Operator

16b. Kind of Business/Industry

Plumbing

17. Father's Name (First, Middle, Last)

Walter Galenski

18. Mother's Name (First, Middle, Maiden Surname)

Anna Zalenski

19a. Informant's Name/Relationship (Type, Print)

Patsy Johnson/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 193, Lottsburg, Virginia

20a. Method of Disposition

1X Burial 2□ Cremation 3□ Removal from State
4□ Donation 5□ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Saint Stanislaus Cemetery

Date

July 1,
1997

20c. Location - City or Town, State

South Deerfield,
Massachusetts

21. Signature of Funeral Service Licensee

#M00690

22. Name and Address of Facility

Wrisley Funeral Home

207 Sugarloaf Street, South Deerfield, MA 01373

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Carcinoma of Lung With Metastases

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

3 Months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death?

1X Yes 2□ No 3□ Probably 4□ Unknown

24a. Was an autopsy
performed?

1□ Yes 2X No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1□ Yes 2□ No

25. Was case referred to medical
examiner?

1□ Yes 2X No

26. Place of Death (Check only one)

Hospital:

1□ Inpatient 2□ ER/Outpatient 3□ DOA

Other:

4□ Nursing Home 5X Residence 6□ Other (Specify)

27. Manner of Death

1X Natural 5□ Pending
Investigation
2□ Accident 6□ Could not be
determined
3□ Suicide
4□ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1□ Yes 2□ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner as stated.

29b. Signature and title of certifier

29c. License number

D14799

29d. Date signed (Month, Day, Year)

June 30, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

k. Joseph Matthew, M.D. 6510 Kenilworth Avenue #1400, Riverdale, Maryland 20737

State
Registrar

31. Data filed (Month, Day, Year)

JUL 03 1997

32. Registrar's Signature

Julia Keiden-Randall

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21273

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) KAREN E. GOODMAN				2. Date of Death Month Day Year JUNE 29, 1997		3. Time of Death 13:55 PM									
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death CITY									
Funeral Director	5. Social Security Number 212-70-6728		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 39 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JULY 13 1957	9. Birthplace (State or Foreign Country) MARYLAND								
	Usual Residence of Decedent															
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location ARNOLD		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
	10e. Street and Number 792 MATCH POINT ROAD				10f. Zip Code 21012		10g. Citizen of What Country? US									
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK									
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 0				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PACKER		16b. Kind of Business/Industry CARR LOWREY GLASS CO.									
	17. Father's Name (First, Middle, Last) BERNARD W. CLEMONS				18. Mother's Name (First, Middle, Maiden Surname) HAZEL GRIFFIN											
	19a. Informant's Name/Relationship (Type, Print) DOUGLAS GOODMAN (HUSBAND)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 792 MATCH POINT RD. ARNOLD, MD. 21012											
	20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ARBUTUS MEM. PARK		Date 7/5/97		20c. Location - City or Town, State BALTIMORE, MD.									
	21. Signature of Funeral Service Licensee Larry S. Reese				22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401											
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. ADULT RESPIRATORY DISTRESS SYNDROME</td> <td rowspan="4">Approximate Interval Between Onset and Death 3 weeks</td> </tr> <tr> <td>Due to (or as a consequence of): LYMPHOMA</td> </tr> <tr> <td>b. Due to (or as a consequence of):</td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>d. Due to (or as a consequence of):</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. ADULT RESPIRATORY DISTRESS SYNDROME	Approximate Interval Between Onset and Death 3 weeks	Due to (or as a consequence of): LYMPHOMA	b. Due to (or as a consequence of):	c. Due to (or as a consequence of):	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	d. Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)	a. ADULT RESPIRATORY DISTRESS SYNDROME	Approximate Interval Between Onset and Death 3 weeks														
	Due to (or as a consequence of): LYMPHOMA															
	b. Due to (or as a consequence of):															
	c. Due to (or as a consequence of):															
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	d. Due to (or as a consequence of):															
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)														
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28e. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No										
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred												
		28f. Location (Street and Number or Rural Route Number, City or Town, State)														
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																
29b. Signature and title of certifier Robert Orłowski MD PhD				29c. License number D46104		29d. Date signed (Month, Day, Year) JUNE 29, 1997										
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ROBERT ORŁOWSKI, 600 N. WOLFE ST, BALTIMORE MD 21264																
31. Date filed (Month, Day, Year) JUL 07 1997		32. Registrar's Signature John Davidson-Rodette														

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21274

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Annie Grant

2. Date of Death

Month Day Year
June 22 1997

3. Time of Death

1:30 PM

4a. Facility Name (If not institution, give street and number)

Genesis ElderCare - The Pines

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

5. Social Security Number

255-64-5103

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 2, 1914

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Caroline

10c. City, Town or Location

Preston

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

22030 Marsh Creek Road

10f. Zip Code

21655

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Labor

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Virginia Sharp (friend)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

22030 Marsh Creek Rd., Preston, Maryland 21655

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Pleasant Cemetery

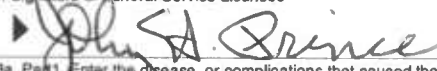
Date

6/28/97

20c. Location - City or Town, State

Preston, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Bennie Smith funeral Home
P.O. Box 1687, Easton, Maryland 21601

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Cerebrovascular accident

Due to (or as a consequence of):

b.

Amyloid angiopathy

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

weeks

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Ronal insufficiency

Anemia

Alcoholism, by history

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

DZ5933

29d. Date signed (Month, Day, Year)

6-24-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL CROWLEY, MD 508 IDLEWIND AVENUE EASTON, MD 21601

31. Date filed (Month, Day, Year)

JUN 30 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21275

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JACK R GREENWOOD				2. Date of Death Month 06 Day 23 Year 97		3. Time of Death 1120	
	4a. Facility Name (If not institution, give street and number) 822 SOUTH SHUMAKER DRIVE				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 549-60-9389		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 53 Yrs.		8. Date of Birth (Month, Day, Year) 09-02-43	
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State Maryland		10b. County Wicomico		10c. City, Town or Location Salisbury	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 822 S. Schumaker Dr., Apt. 302		10f. Zip Code 21804		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Navy		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrator		16b. Kind of Business/Industry Healthcare				
17. Father's Name (First, Middle, Last) Robert Charles Greenwood				18. Mother's Name (First, Middle, Maiden Surname) Barbara Jean Williams				
19a. Informant's Name/Relationship (Type, Print) Jennifer L. Taylor/daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 308 Main St., Watsontown, PA 17777				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory		20c. Location - City or Town, State 6/25/97 Salisbury, MD				
21. Signature of Funeral Service Licensee  MO1051		22. Name and Address of Facility Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. ASPHYXIATION Due to (or as a consequence of): b. DRUG INTOXICATION Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier  D.M.E.				29c. License number D03599		29d. Date signed (Month, Day, Year) 06-23-97		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) JOHN T. BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY, MD 21801								
31. Date filed (Month, Day, Year) JUN 26 1997		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21276

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Ethel Henson</i>				2. Date of Death Month <i>6</i> Day <i>26</i> Year <i>97</i>		3. Time of Death <i>12:37PM</i>												
	4a. Facility Name (If not institution, give street and number) <i>Ann Arundel General Hospital</i>				4b. City, Town, or Location of Death <i>Annapolis</i>		4c. County of Death <i>Anne Arundel</i>												
Funeral Director	5. Social Security Number <i>212-20-5153</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>77</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>2-4-20</i>	9. Birthplace (State or Foreign Country) <i>South Carolina</i>											
	Usual Residence of Decedent																		
To Be Completed by Funeral Director	10a. State <i>MD</i>	10b. County <i>Anne Arundel</i>	10c. City, Town or Location <i>Severna Park</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
	10e. Street and Number <i>129 W. Earleigh Heights</i>			10f. Zip Code <i>21146</i>		10g. Citizen of What Country? <i>USA</i>													
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>												
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th</i> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Home Maker</i>			16b. Kind of Business/Industry <i>Domestic</i>													
	17. Father's Name (First, Middle, Last) <i>Henry McQueen Bey</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Mattie</i>														
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <i>Beverly Butler</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>616 Admiral Siewe Apt 354 Annapolis, Md.</i>														
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Hillcrest Memorial</i>		20c. Location - City or Town, State <i>Annapolis, Md.</i>		20d. Date <i>7/23/97</i>												
	21. Signature of Funeral Service Licensee <i>Jeff Miller</i>				22. Name and Address of Facility <i>House of Sticks #1 1922 Forest Dr Annapolis, Md.</i>														
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																		
	<table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <i>Aspiration Pneumonia</i></td> <td>Approximate Interval Between Onset and Death <i>1 week</i></td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. <i>Advanced Parkinson's Disease</i></td> <td><i>2 Years</i></td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> <tr> <td colspan="2">Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Bacterial Sclerotic Cardiovascular Disease</i> <i>Pernicious Anemia</i></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. <i>Aspiration Pneumonia</i>	Approximate Interval Between Onset and Death <i>1 week</i>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <i>Advanced Parkinson's Disease</i>	<i>2 Years</i>	c.		d.		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Bacterial Sclerotic Cardiovascular Disease</i> <i>Pernicious Anemia</i>
Immediate Cause (Final disease or condition resulting in death)	a. <i>Aspiration Pneumonia</i>	Approximate Interval Between Onset and Death <i>1 week</i>																	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <i>Advanced Parkinson's Disease</i>	<i>2 Years</i>																	
	c.																		
	d.																		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Bacterial Sclerotic Cardiovascular Disease</i> <i>Pernicious Anemia</i>																		
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No											
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred											
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>William H. Attending Doctor</i>		29c. License number <i>021684</i>		29d. Date signed (Month, Day, Year) <i>6.26.97</i>													
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>C. V. CYRIAC M.D. 8109 RITCHIE HWY, PASADENA, MD 21122</i>																			
31. Date filed (Month, Day, Year) <i>JUL 03 1997</i>		32. Registrar's Signature <i>John Davidson-Randall</i>																	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21277

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James Bernard Harley, Jr.				2. Date of Death Month June Day 30 Year 1997		3. Time of Death 11:40p.m.	
	4a. Facility Name (If not institution, give street and number) 9145 Hawthorne Road				4b. City, Town, or Location of Death La Plata		4c. County of Death Charles	
Funeral Director	5. Social Security Number 579-16-4518	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) SEPT. 2, 1915		9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MARYLAND	10b. County CHARLES	10c. City, Town or Location LA PLATA			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 9145 HAWTHORNE ROAD			10f. Zip Code 20646		10g. Citizen of What Country? UNITED STATES		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW-2		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: AMERICAN INDIAN	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 0			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) EQUIPMENT OPERATOR		16b. Kind of Business/Industry STATE HIGHWAY ADMINISTRATION		
	17. Father's Name (First, Middle, Last) JAMES BERNARD HARLEY, SR.				18. Mother's Name (First, Middle, Maiden Surname) MARTHA ANN NEWMAN			
	19a. Informant's Name/Relationship (Type, Print) JAMES A. HARLEY - SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2385 DAVIS ROAD, WALDORF, MARYLAND 20603			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) RESURRECTION CEMETERY, JULY 5, 1997 CLINTON, MARYLAND		Date		20c. Location - City or Town, State	
	21. Signature of Funeral Service Licensee MARK G. BROHAWN M00053				22. Name and Address of Facility THE HUNT FUNERAL HOME, INC. P.O. BOX 156, WALDORF, MARYLAND 20604			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CANCER OF LUNG Due to (or as a consequence of): b. METASTATIC Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							Approximate Interval Between Onset and Death Months
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Krishan Mathur		29c. License number D28352		29d. Date signed (Month, Day, Year) July 1, 1997		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Krishan Mathur, M.D. - P. O. Box 2729, La Plata, MD 20646								
31. Date filed (Month, Day, Year) JUL 03 1997		32. Registrar's Signature Julia Davidson-Randall						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21278

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Steven Edward Harris

2. Date of Death

Month Day Year
June 26 1997

3. Time of Death

2:59PM

4a. Facility Name (If not institution, give street and number)

The Memorial Hospital

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral
Director

5. Social Security Number

220-28-2110

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

62

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
01-20-35

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Caroline

10c. City, Town or Location

Greensboro

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

603 W. Sunset Ave.

10f. Zip Code

21639

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify:

Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

10th

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Factory

17. Father's Name (First, Middle, Last)

James Morgan

18. Mother's Name (First, Middle, Maiden Surname)

Pearl Harris

19a. Informant's Name/Relationship (Type, Print)

Rena Dill (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

309 Choptank Ave., Cambridge, Maryland 21613

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Sandtown Cemetery

Date

7/1/97

20c. Location - City or Town, State

Hillsboro, Maryland

21. Signature of Funeral Service Licensee

John A. Quince

22. Name and Address of Facility

Bennie Smith Funeral Home
1687, P.O. Box, Easton, Maryland 2160123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Acute myocardial infarction; cardiac arrest sudden

Due to (or as a consequence of):

b. Arteriosclerosis cardiac vascular disease year

Due to (or as a consequence of):

c. Essential Hypertension year

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus, insulin dependent

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Philip Felipe

29c. License number

D01653

29d. Date signed (Month, Day, Year)

6/30/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Philip Felipe 510 S. 5th Ave., Denton, Md. 21629

31. Date filed (Month, Day, Year)

6/30/97 JUN 30 1997

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21279

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GEORGIA Hodges				2. Date of Death Month 6 Day 21 Year 97		3. Time of Death 0330	
	4a. Facility Name (If not institution, give street and number) 10602 Flower Street				4b. City, Town, or Location of Death Berlin		4c. County of Death Worcester	
Funeral Director	5. Social Security Number 262-46-6708		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) 10/7/1918	
	10a. State Maryland		10b. County Worcester		10c. City, Town or Location Berlin		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	Usual Residence of Decedent				10f. Zip Code 21811		10g. Citizen of What Country? U.S.	
	11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic Work		14. Race - American Indian, Black, White, etc. Specify: Black	
	17. Father's Name (First, Middle, Last) George Adams				18. Mother's Name (First, Middle, Maiden Surname) Estella Cole			
	19a. Informant's Name/Relationship (Type, Print) Clarence V. DeLancey, Jr./Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10602 Flower Street Berlin, Maryland 21811			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery		20c. Date 6/28/97		20d. Location - City or Town, State West Palm Beach, FL	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Lewis N. Watson Funeral Home, 1618 West Rd., Salisbury, MD			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Carcinoma of the Colon - Metastatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28e. Piece of injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
Physician /Medical Examiner	29b. Signature and title of certifier 				29c. License number 019576		29d. Date signed (Month, Day, Year) 6/21/97	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) W R Schmitt, MD 11220 Beauchamp Rd, Berlin MD 21811							
State Registrar	31. Date filed (Month, Day, Year) JUN 24 1997				32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 21280

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GEORGE JARMAN

2. Date of Death
Month Day Year

6 - 26 - 97

3. Time of Death

10:59 a.m.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

ATLANTIC GENERAL HOSPITAL

4b. City, Town, or Location of Death

BERLIN, M.D.

4c. County of Death

WORCESTER

5. Social Security Number

217-148257

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
5-20-14

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

NJ

10b. County

Atlantic County

10c. City, Town or Location

Pleasantville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1200 Lincoln Avenue

10f. Zip Code

08232

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Navar Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Isaac Jarman

18. Mother's Name (First, Middle, Maiden Summa)

Lavinia Dennis

19a. Informant's Name/Relationship (Type, Print)

Lucinda M. Evans

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1200 Lincoln Ave., P. O. Box 1252, Pleasantville, NJ

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Paul's Cemetery

Date

7/1/97

20c. Location - City or Town, State

Berlin, MD 21801

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Lewis N. Watson Funeral Home
1618 West Rd., Salisbury, MD 21801

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPTIC SHOCK FROM PROB. RUPTURED VISCUS OWE
Due to (or as a consequence of): TO RECTO-VAGINAL FISTULA R/O
DUE TO TUMOR EROSION

Approximate Interval Between Onset and Death

w/in 24 HRS.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. URSEPSIS
Due to (or as a consequence of):

3 DAYS

c. RENAL FAILURE
Due to (or as a consequence of):

3 DAYS

d. LEFT PERIHILAR INFILTRATE
Due to (or as a consequence of):

3 DAYS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DM II

ALZHEIMER'S DISEASE

ASCVD

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. M. Lewis M.D.

29c. License number

J0050929

29d. Date signed (Month, Day, Year)

6-27-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOY MADARANG-LEWIS #18 MASON-DIXON SHOPPING CENTER SELBYVILLE, DE 19975

31. Date filed (Month, Day, Year)

JUN 30 1997

32. Registrar's Signature

John Andrew Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21281

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ORVILLE LEROY JAY			2. Date of Death Month Day Year June 24, 1997		3. Time of Death 10:45 pm		
	4a. Facility Name (If not institution, give street and number) Memorial Hospital			4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany		
Funeral Director	5. Social Security Number 177-16-5225		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) 2-16-18	
	9. Birthplace (State or Foreign Country) MONROE TWP. PA.		10a. State PA.		10b. County BEDFORD		10c. City, Town or Location CLEARVILLE	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number RD#2 BOX 28R		10f. Zip Code 15535		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1941- If Yes, Give Year or Dates: 1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8TH College (1-4 or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LIFETIME FARMER		16b. Kind of Business/Industry FARMING			
	17. Father's Name (First, Middle, Last) ALVA JAY		18. Mother's Name (First, Middle, Maiden Surname) MINNIE M. MORSE		19a. Informant's Name/Relationship (Type, Print) DEBBIE CLARK		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RD#2 CLEARVILLE, PA. 15535	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) FAIRVIEW CEMETERY		Date 6-27		20c. Location - City or Town, State MANN TWP., PA.	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility DALLA VALLE FUNERAL SVC. 22 W. MAIN ST. EVERETT, PA. 15537		23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 12 Years	
	23f. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pulmonary Hypertension Renal Failure		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	
	28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
	28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D 14865	
29d. Date signed (Month, Day, Year) JUNE 25, 1997		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Robustiano Barrera-Memorial Medical Building-Cumberland, MD 21502		31. Date filed (Month, Day, Year) JUL 01 1997		32. Registrar's Signature 		

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

THE ...

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21282

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Corwin Tirrell Jewell, Jr.

2. Date of Death

Month Day Year
June 30, 1997

3. Time of Death

3:20 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

4469 World Farm Road

4b. City, Town, or Location of Death

Oxford

4c. County of Death

Talbot

5. Social Security Number

105-18-7960

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 12, 1925

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Talbot

10c. City, Town or Location

Oxford

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4469 World Farm Road

10f. Zip Code

21654

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Chemical Engineer

16b. Kind of Business/Industry

Publishing

17. Father's Name (First, Middle, Last)

Corwin T. Jewell, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Frances Kested

19a. Informant's Name/Relationship (Type, Print)

Seth Shannahan Jewell/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4469 World Farm Rd., Oxford, Maryland 21654

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Cremation Center LLC

Date

7/7

20c. Location - City or Town, State

Chester, Md 21619

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fellows, Helfenbein & Newnam Funeral Home
200 S. Harrison St., Easton, MD 21601

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Metastatic carcinoma of lung to Brain and Spine

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 mo

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Non-small Cancer of lung

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

Recurrent Head and Neck Cancer

Hypertension

Benign Prostatic Hyper trophy

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D08715

29d. Date signed (Month, Day, Year)

7/2/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William H. Wood, Jr., MD 506 Idlewild Ave., Easton, MD 21601

31. Date filed (Month, Day, Year)

JUL - 2 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-691-2020.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21283

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

ALEXANDER

2. Date of Death

Month Day Year
JULY 1, 1997

3. Time of Death

7:15AM

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

213-36-2704

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

58 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
MAY 18 1939

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

ANNAPOLIS

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

12 MONUMENT STREET

10f. Zip Code

21401

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

LABORER

16b. Kind of Business/Industry

SELF EMPLOYED

17. Father's Name (First, Middle, Last)

ALEXANDER JOHNSON

18. Mother's Name (First, Middle, Maiden Surname)

FLORENCE SNOWDEN

19a. Informant's Name/Relationship (Type, Print)

ADELA BROWN (SISTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

205 EASTERN AVE. ANNAPOLIS, MD. 21403

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

ANNAPOLIS MEM. GARDENS

Date

7/7/97

20c. Location - City or Town, State

ANNAPOLIS, MD.

21. Signature of Funeral Service Licensee

Harry B. Reese

22. Name and Address of Facility

WM. REESE & SONS MORTUARY, P.A.
821 WEST ST. ANNAPOLIS, MD. 2140123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Cancer of the esophagus

Due to (or as a consequence of):

b. gastrointestinal bleeding

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

months

days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Cherelle Reddick-Lane

29c. License number

H48247

29d. Date signed (Month, Day, Year)

July 1, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Cherelle Reddick-Lane, North Arundel Hospital 301 Hospital Drive
Glen Burnie, MD

31. Date filed (Month, Day, Year)

JUL 07 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21284

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MABLE LOTTIE JOHNS						2. Date of Death Month Day Year June 28 1997		3. Time of Death 8:30 p	
	4a. Facility Name (If not institution, give street and number) The Memorial Hospital						4b. City, Town, or Location of Death Easton		4c. County of Death Talbot	
Funeral Director	5. Social Security Number 220-03-8983		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) Mar. 6, 1918		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Talbot		10c. City, Town or Location Easton				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 6371 Old Trappe Road				10f. Zip Code 21601		10g. Citizen of What Country? United States			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurses Aide				16b. Kind of Business/Industry Easton Memorial Hospital			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Samuel Brice						18. Mother's Name (First, Middle, Maiden Surname) Lottie Mable Walley			
	19a. Informant's Name/Relationship (Type, Print) Lottie Mable Barrow/Daugh.						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6371 Old Trappe Rd., Easton, MD 21601			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Spring Hill Cemetery		Date 7-2		20c. Location - City or Town, State Easton, Maryland			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Frampton-Hawkins-Eskow Funeral Home PO Box 43, Federalsburg, MD 21632					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Aspiration Pneumonia Due to (or as a consequence of): b. Endstage OHS Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 24 hrs 5 years	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Seizure Disorder, Non insulin Dep. DM Anemia of chronic disease								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
State Registrar	29b. Signature and title of certifier 				29c. License number D33294		29d. Date signed (Month, Day, Year) 6/29/97			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Robinson Lappin, M.D., Shore Clinical Found., 920 Market St. Denton MD 21629									
	31. Date filed (Month, Day, Year) JUL - 2 1997				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21285

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

PREM L. KANSAL

2. Date of Death

Month Day Year
JUNE 30 1997

3. Time of Death

2:00 PM

4a. Facility Name (If not institution, give street and number)

MEMORIAL HOSPITAL & MEDICAL CENTER

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

Funeral
Director

5. Social Security Number

208-62-8052

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
MARCH 27 1935

9. Birthplace (State or Foreign Country)

INDIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ALLEGANY

10c. City, Town or Location

CUMBERLAND

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1054 RICHWOOD AVE.

10f. Zip Code

21502

10g. Citizen of What Country?

India

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Other Asian or
Pacific Islander
Specify:15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

HOUSE KEEPER

16b. Kind of Business/Industry

HOUSE KEEPER

17. Father's Name (First, Middle, Last)

RAGHBIV GARG

18. Mother's Name (First, Middle, Maiden Surname)

KRISHUA (UNKNOWN)

19a. Informant's Name/Relationship (Type, Print)

DR SUNIL GUPTA SON IN LAW

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1054 RICHWOOD AVE CUMBERLAND MARYLAND 21502

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

CUMBERLAND CREMATORY JULY 1, 1997 CUMBERLAND MARYLAND

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licenses

22. Name and Address of Facility

MERRITT-ADAMS FUNERAL HOME
404 DECATUR STREET CUMBERLAND MARYLAND23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Metastatic endometrial carcinoma

6 months

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery disease, Diabetis mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)29b. Signature and title of certifier

29c. License number
D 33280
29d. Date signed (Month, Day, Year)
June 30, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUNIL GUPTA M.D., 625 KENT AVENUE, SUITE 101, CUMBERLAND, MD 21502

31. Date filed (Month, Day, Year)

JUL 02 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23b or 24a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

PREM KANSAL

Division of Vital Records, P.O. Box 68760,

1
MKState
Registrar

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that this is essential for the proper management of the organization's finances and for ensuring transparency to stakeholders.

2. The second part of the document outlines the specific procedures for recording transactions. It details the steps involved in the accounting process, from the initial recording of a transaction to the final posting to the general ledger.

3. The third part of the document discusses the importance of reconciling accounts. It explains how regular reconciliations help to identify and correct errors, ensuring that the financial records are accurate and reliable.

4. The fourth part of the document discusses the importance of maintaining proper documentation. It emphasizes that all transactions should be supported by appropriate evidence, such as invoices, receipts, and contracts, to ensure the integrity of the financial records.

5. The fifth part of the document discusses the importance of regular audits. It explains how audits help to ensure that the financial records are accurate and that the organization is complying with applicable laws and regulations.

6. The sixth part of the document discusses the importance of maintaining proper internal controls. It explains how internal controls help to prevent and detect errors and fraud, ensuring the accuracy and reliability of the financial records.

7. The seventh part of the document discusses the importance of maintaining proper communication. It emphasizes that all financial transactions should be properly documented and communicated to the appropriate parties, ensuring transparency and accountability.

8. The eighth part of the document discusses the importance of maintaining proper security. It explains how proper security measures help to protect the financial records from unauthorized access, ensuring the confidentiality and integrity of the information.

9. The ninth part of the document discusses the importance of maintaining proper backup procedures. It emphasizes that all financial records should be regularly backed up, ensuring that the information is preserved in the event of a disaster.

10. The tenth part of the document discusses the importance of maintaining proper archiving procedures. It explains how proper archiving helps to ensure that financial records are properly stored and can be retrieved when needed, ensuring the long-term availability of the information.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21286

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) IDA M. KESELING				2. Date of Death Month Day Year June 26 1997		3. Time of Death 8:30pm		
	4a. Facility Name (If not institution, give street and number) Charlestown Retirement Community				4b. City, Town, or Location of Death Catonsville		4c. County of Death Baltimore City		
Funeral Director	5. Social Security Number 217-03-0170		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Apr. 13, 1912	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MD		10b. County Baltimore City		10c. City, Town or Location Catonsville		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 209 S 709 Maiden Choice Lane				10f. Zip Code 21228		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Domestic				
	17. Father's Name (First, Middle, Last) Harry Wicks				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Myers				
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mrs. Jeanne K. Lintner				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5623 Manor Drive, Woodbine, MD 21797				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery		Date 6/30/97		20c. Location - City or Town, State Baltimore, MD		
	21. Signature of Funeral Service Licensee Brian L. Haight				22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL (Box 195) Sykesville, MD 21784 (410)-795-1400				
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <u>Arteriosclerotic Cardiovascular Disease</u> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEMENTIA									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier Bernard F. Kozlovsky				29c. License number DZ6473		29d. Date signed (Month, Day, Year) June 27, 1997			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) BERNARD F KOZLOVSKY, MD 711 MAIDEN CHOICE LANE 21228									
31. Date filed (Month, Day, Year) JUN 30 1997				32. Registrar's Signature John Andrew Randall					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Amended #206, 7/1/97
N/A, Allegany County

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21287

Theodore Morris Kimble

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Theodore Kimble				2. Date of Death Month Day Year June 30 1997		3. Time of Death 2:30AM	
	4a. Facility Name (If not institution, give street and number) Sinai Hospital of Baltimore				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 212 34 6381		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 63 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 22, 1933	9. Birthplace (State or Foreign Country) West Virginia
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD		10b. County Allegany		10c. City, Town or Location Westernport		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 22612 Westernport Road, S.W.				10f. Zip Code 21562		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: Korean		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th. College (1-4or 5+) 12th.				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Power Boiler Operator		16b. Kind of Business/Industry Pulp & Paper	
	17. Father's Name (First, Middle, Last) Charles Adam Kimble				18. Mother's Name (First, Middle, Maiden Surname) Mary Thelma Mackley			
	19a. Informant's Name/Relationship (Type, Print) Steven Kimble				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 106 Morning View Drive, Keyser, WV 26726			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Potomac Memorial Gardens		Date 7/3/97		20c. Location - City or Town, State Keyser, West Virginia	
	21. Signature of Funeral Service Licensee Thomas J. Skarda				22. Name and Address of Facility SKARDA JFF 2829 HURSTON ST FAC TO MD. 21224			
	23e. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Rupture of thoracic aortic aneurysm Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
	Approximate Interval Between Onset and Death 45 minutes							
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury et Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier Theresa Lynn Hartsell, MD, PhD				29c. License number A52402321-TH-9527		29d. Date signed (Month, Day, Year) June 30, 1997	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Theresa Lynn Hartsell, MD, PhD Sinai Hospital of Baltimore Baltimore, MD 21215							
State Registrar	31. Date filed (Month, Day, Year) JUL 01 1997				32. Registrar's Signature John H. Hartsell			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21288

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ellen N. Limbert

2. Date of Death

Month
JulyDay
01Year
1997

3. Time of Death

4:15PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Ginger Cove Health Care Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

090-05-4324

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

89

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

July 27 1907

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4000 River Crescent Drive

10f. Zip Code

21401

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

David Newlands

18. Mother's Name (First, Middle, Maiden Surname)

Jeanie Campbell

19a. Informant's Name/Relationship (Type, Print)

Lee M. Limbert, Jr. (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1012 N. Noyes Drive Silver Spring, Maryland 20910

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ft. Lincoln Crematory July 3, 1997 Brentwood, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

John M. Taylor Funeral Home, Inc.

147 Duke of Gloucester St. Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive heart failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 mos

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D30718

29d. Date signed (Month, Day, Year)

July 02, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

(410-573-1110)

John D. Jackson, M.D. 2003 Medical Parkway Suite 100 Annapolis, Maryland 21401

31. Date filed (Month, Day, Year)

JUL 03 1997

32. Registrar's Signature

Julia Davidson-Rodell

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21289

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William Calvin Livingston			2. Date of Death Month Day Year June 22 1997		3. Time of Death 6:45 PM		
	4a. Facility Name (If not institution, give street and number) Salisbury Center: Genesis ElderCare			4b. City, Town, or Location of Death Salisbury, MD		4c. County of Death Wicomico		
Funeral Director	5. Social Security Number 214-28-8581		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 60 Yrs.		8. Date of Birth (Month, Day, Year) July 6, 1936	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Wicomico		10c. City, Town or Location Salisbury	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 1525 Woodridge Dr.		10f. Zip Code 21804		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Planning Director		16b. Kind of Business/Industry County Government			
	17. Father's Name (First, Middle, Last) William Calvin Livingston			18. Mother's Name (First, Middle, Maiden Surname) Mildred Bertha Smith				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mary B. Livingston - wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1525 Woodridge Dr. Salisbury, MD 21804				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parsons Cemetery		20c. Location - City or Town, State 6-25-97 Salisbury, MD			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee B. Keith Phyllis, CFS			22. Name and Address of Facility 705 E. Main St. Bounds Funeral Home Salisbury, MD 21804				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. METASTATIC Lung Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last f. Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of):							Approximate Interval Between Onset and Death 8 months
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred					28e. Location (Street and Number or Rural Route Number, City or Town, State)		
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					29b. Signature and title of certifier W. D. M.		
	29c. License number D39843		29d. Date signed (Month, Day, Year) 6/24/97					
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) W. D. M. 1104 Healthway Dr., Salisbury, MD 21804							
	31. Date filed (Month, Day, Year) JUN 24 1997					32. Registrar's Signature John Davidson Randall		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21290

Item # 5, 7/8/97 WCHD jrd

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Leon P. LLOYD

2. Date of Death

Month Day Year
June 13 1997

3. Time of Death

2041

4a. Facility Name (If not institution, give street and number)

Peninsula Regional Medical Center

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

5. Social Security Number

206-20-0226

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

68

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 18 1929

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

PA

10b. County

10c. City, Town or Location

Philadelphia

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7270 Mansfield Avenue

10f. Zip Code

19138

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12College (1-4 or 5+)
2

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Police Man

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Herman S. LLOYD

18. Mother's Name (First, Middle, Maiden Surname)

Gilberta E. Gibbons

19a. Informant's Name/Relationship (Type, Print)

Juanita LLOYD (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7270 Mansfield Ave. Phila. Pa 19138

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rolling Green Mem. Pk. Cem.

Date

6-19-97

20c. Location - City or Town, State

Westchester, PA.

21. Signature of Funeral Service Licensee

Gladys B. Stewart

22. Name and Address of Facility

Stewart Funeral Home
821 West Rd. Salisbury, Md. 21801

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. HYPERTENSIVE CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John T. Bulkeley D.M.E.

29c. License number

D03599

29d. Date signed (Month, Day, Year)

06-13-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN T. BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY, MD 21801

31. Date filed (Month, Day, Year)

JUN 24 1997

32. Registrar's Signature

John Davidson Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21291

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WESLEY DOYLE MCGUTHRY						2. Date of Death Month Day Year JUNE 26 1997		3. Time of Death 7:39 am	
	4a. Facility Name (If not institution, give street and number) FORT WASHINGTON HOSPITAL						4b. City, Town, or Location of Death FORT WASHINGTON		4c. County of Death PRINCE GEORGE'S	
Funeral Director	5. Social Security Number 259-50-0642		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 67 Yrs.		8. Date of Birth (Month, Day, Year) APR 13, 1930		9. Birthplace (State or Foreign Country) GA	
	Usual Residence of Decedent									
10a. State MD		10b. County Prince George's		10c. City, Town or Location Ft. Washington				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 12539 Monterey Circle				10f. Zip Code 20744		10g. Citizen of What Country? USA				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1955-77		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Management Director, Information Service		16b. Kind of Business/Industry Metro - Transportation				
17. Father's Name (First, Middle, Last) John Matthew McGuthry						18. Mother's Name (First, Middle, Maiden Summa) Arlene Louise Stephens				
19a. Informant's Name/Relationship (Type, Print) Mildred McGuthry						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12539 Monterey Circle, Ft. Washington, MD 20744				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Cheltenham VA Cemetery		Date 7-2-97		20c. Location - City or Town, State Cheltenham, MD			
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility FELTON FUNERAL SERVICES P.O. Box 1351, Forestville, MD 20747				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute cardiac arrest Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death Few hours										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Adenocarcinoma of the Prostate gland Lumbar disc disease										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D-24687		29d. Date signed (Month, Day, Year) 6-27-97				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) SANTIAGO D. MORAO, JR., M.D. 6354 OXON HILL RD. OXON HILL, MD, 20745										
31. Date filed (Month, Day, Year) JUL 01 1997		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21292

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Emma McKnight				2. Date of Death Month June Day 28 Year 1997		3. Time of Death 2:05 PM	
	4a. Facility Name (If not institution, give street and number) Chesapeake Health Care Center				4b. City, Town, or Location of Death Arnold		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 229-74-4732	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept 22 1916		9. Birthplace (State or Foreign Country) Virginia
	Usual Residence of Decedent							
10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Severn		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 7409 Merrimusic Avenue Circle				10f. Zip Code 21144		10g. Citizen of What Country? Anne Arundel		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cook		16b. Kind of Business/Industry Food		
17. Father's Name (First, Middle, Last) Edd Reavis				18. Mother's Name (First, Middle, Maiden Surname) Zella Higgins				
19a. Informant's Name/Relationship (Type, Print) Betty Evans (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Circle 7409 Merrimusic Avenue Severn, Maryland 21144				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Monta Vista Cemetery		20c. Date July 2, 1997		20d. Location - City or Town, State Galax, Virginia		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. metastatic fibrosarcoma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pleural mass, psoas mass, liver mass, malignant pleural effusion congestive heart failure, hypertension chronic obstructive pulmonary disease						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number D41955		29d. Date signed (Month, Day, Year) 6-30-97		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) REBECCA D. ELTON MD Broadneck Medical Center, Arnold MD 21012								
31. Date filed (Month, Day, Year) JUL 03 1997		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

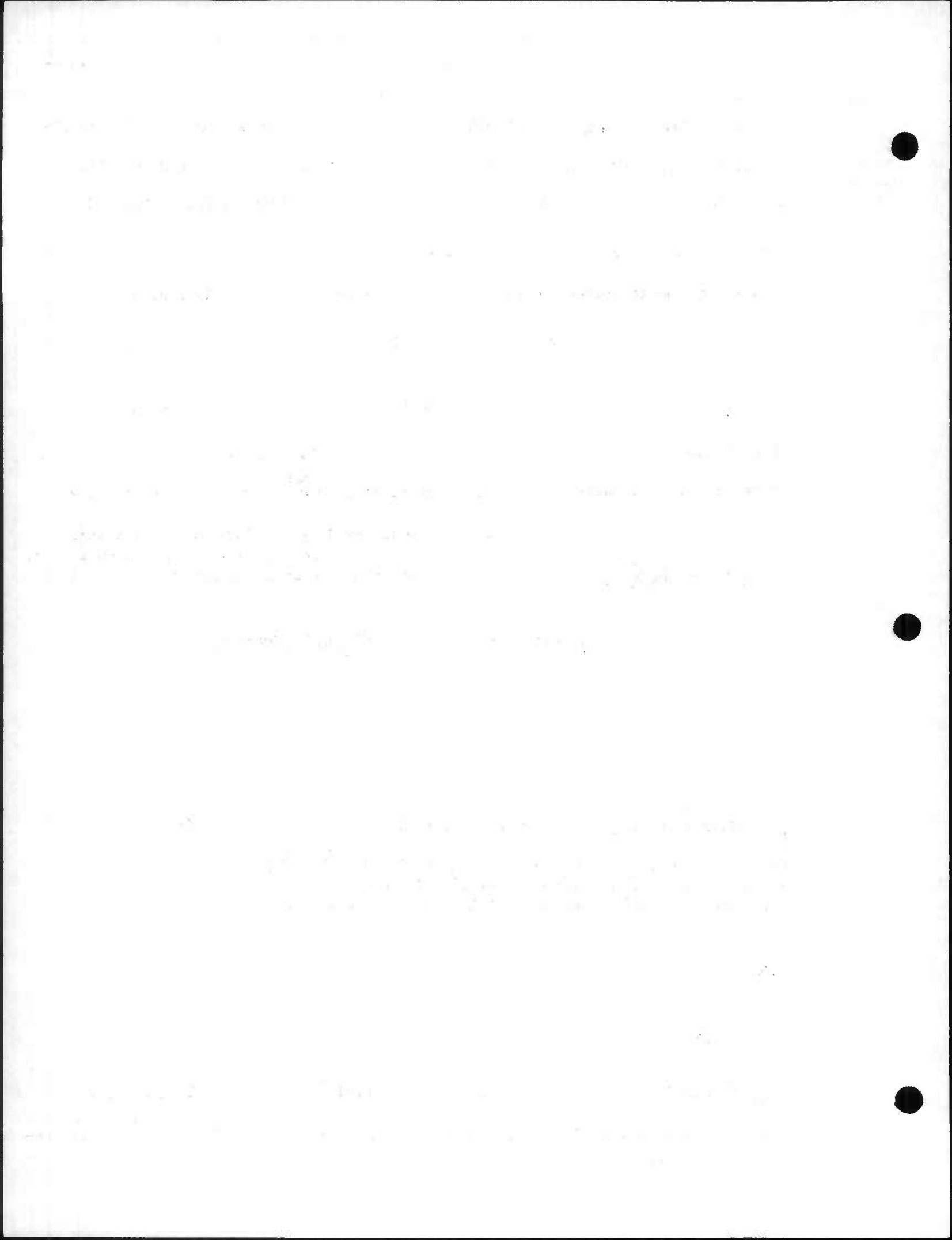
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21293

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Emmer Brice McMillan				2. Date of Death Month Day Year June 28 97		3. Time of Death 1:55 P.M.	
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital				4b. City, Town, or Location of Death Clinton		4c. County of Death Prince George's Co.	
Funeral Director	5. Social Security Number 215-24-5689		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) January 1, 1906	9. Birthplace (State or Foreign Country) North Carolina
	Usual Residence of Decedent				10a. State Maryland		10b. County Prince George's	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 11209 Keystone Avenue		10f. Zip Code 20735		10g. Citizen of What Country? United States of America
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) Jerry Brice				18. Mother's Name (First, Middle, Maiden Surname) Mary Brice				
19a. Informant's Name/Relationship (Type, Print) David McMillan/ Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11209 Keystone Avenue, Clinton, Maryland 20735				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Murray Cemetery		Date July 1, 1997		20c. Location - City or Town, State Wallace, North Carolina		
21. Signature of Funeral Service Licensee #M00690 Howard A. Carson				22. Name and Address of Facility Matthews Funeral Service, Inc. 308 Elizabeth Street, Wallace, North Carolina				
23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Acute Myocardial Infarction Due to (or as a consequence of): b. Atherosclerosis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 24 Hrs				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dehydration / Severe Dementia Renal Insufficiency SACRAL Decubitus / STROKE IV				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Michael D. Levine		29c. License number D 24945		29d. Date signed (Month, Day, Year) JUNE 29, 1997
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Michael D. Levine, M.D., 7801 Old Branch Avenue #409, Clinton, Maryland 20735								
31. Date filed (Month, Day, Year) JUL 02 1997				32. Registrar's Signature John Davidson-Randall				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.


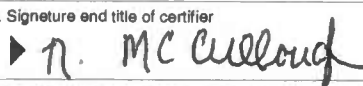

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 21294**
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Richard C. McIlwee				2. Date of Death Month June Day 23 Year 1997		3. Time of Death 1703	
	4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital				4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany	
Funeral Director	5. Social Security Number 217-10-7077	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 28, 1918		9. Birthplace (State or Foreign Country) West Virginia
	Usual Residence of Decedent							
10a. State WV		10b. County Mineral		10c. City, Town or Location Keyser			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 396 Ward Avenue				10f. Zip Code 26726		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Spinning Department		16b. Kind of Business/Industry Textile Manufacturing		
17. Father's Name (First, Middle, Last) Unknown				18. Mother's Name (First, Middle, Maiden Surname) Mary Katharine Hartman				
19a. Informant's Name/Relationship (Type, Print) Lena L. McIlwee				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 396 Ward Avenue Keyser, WV 26726				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Potomac Memorial Gardens		Date June 26 1997		20c. Location - City or Town, State Keyser, WV		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Rotruck-Smith Funeral Home 85 S. Main Street Keyser, WV 26726				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. acute complicated MI Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 72 hr
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D44712		29d. Date signed (Month, Day, Year) June 30, 1997		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nannette McCullough, M.D. 921 Seton Drive, Suite C Cumberland, MD 21502								
31. Date filed (Month, Day, Year) JUL 03 1997		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1890

1890

1890

1890

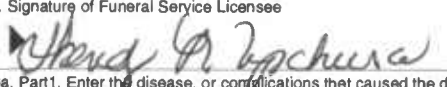


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21295

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Anne F. MacDonald				2. Date of Death Month June Day 27 Year 1997		3. Time of Death 11:15 PM		
	4a. Facility Name (If not institution, give street and number) Mediplex of Montgomery Village				4b. City, Town, or Location of Death Gaithersburg		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 189-10-3984		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) Apr. 14, 1910		
	9. Birthplace (State or Foreign Country) PENNSYLVANIA		10a. State MD		10b. County Montgomery		10c. City, Town or Location Gaithersburg		
Usual Residence of Decedent		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 20429 Ivybridge Court		10f. Zip Code 20879		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Home		17. Father's Name (First, Middle, Last) Charles Reshenberg		18. Mother's Name (First, Middle, Maiden Surname) Fannir Irwin	
19a. Informant's Name/Relationship (Type, Print) Joan MacDonald Evans		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20429 Ivybridge Court - Gaithersburg, MD 20879		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Sunset Memorial Park		20c. Location - City or Town, State 6/30/97 Cumberland, MD	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility George-Upchurch Funeral Home, P.A. 202 Greene St., Cumberland, MD 21502		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. SEPSIS Due to (or as a consequence of): b. DECUBITUS ULCERS Due to (or as a consequence of): c. MALNUTRITION Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 1 YEAR 2 YEARS 2 YEARS			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEMENTIA		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D30692		29d. Date signed (Month, Day, Year) June 30, 1997			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gabriel A. Berrebi, M.D., 15200 Shady Grove Road, #305 Rockville, MD 20850		31. Date filed (Month, Day, Year) JUL 03 1997		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21296

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Betty ANN McKee				2. Date of Death Month JUNE Day 28 , Year 1997		3. Time of Death 13:55 PM	
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 425-58-6521		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 66 Yrs.		8. Date of Birth (Month, Day, Year) June 24, 1931	
	9. Birthplace (State or Foreign Country) Alabama		10a. State MD		10b. County TALBOT		10c. City, Town or Location OXFORD	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 214 SOUTH MORRIS STREET		10f. Zip Code 21654		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry OWN HOME				
17. Father's Name (First, Middle, Last) THOMAS EDWARD HARRIS				18. Mother's Name (First, Middle, Maiden Surname) ETHEL LEE ARNOLD				
19a. Informant's Name/Relationship (Type, Print) KINNIARD ROWE MCKEE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 214 SOUTH MORRIS ST., OXFORD, MD 21654				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) U.S. NAVAL ACADEMY		Date 7/3/97		20c. Location - City or Town, State ANNAPOLIS, MD		
21. Signature of Funeral Service Licensee Mary G. Mum IV		22. Name and Address of Facility Fellows, Helfenbein, & Newnam Funeral Home 200 South Harrison St., Easton, MD 21601						
23a. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gastrointestinal Hemorrhage Due to (or as a consequence of): b. Metastatic Melanoma. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 1 day 1 year								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier W Bowerford MD		29c. License number RES 000		29d. Date signed (Month, Day, Year) June 28 1997				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) W Bowerford MD Tower 110 Johns Hopkins Hospital								
31. Date filed (Month, Day, Year) JUL - 1 1997		32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21297

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Virgil Douglas McCray Sr.				2. Date of Death Month June Day 17 Year 1997		3. Time of Death 1339	
	4a. Facility Name (If not institution, give street and number) Atlantic General Hospital				4b. City, Town, or Location of Death Berlin		4c. County of Death Worcester	
Funeral Director	5. Social Security Number 013-16-1453		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) 11/20/1916	
	9. Birthplace (State or Foreign Country) Delaware		10. Usual Residence of Decedent 10a. State Delaware 10b. County Sussex 10c. City, Town or Location Frankford 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black		14. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) poultry worker		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) --		16. Kind of Business/Industry poultry industry	
	17. Father's Name (First, Middle, Last) Joseph Henry McCray		18. Mother's Name (First, Middle, Maiden Surname) Frances Collick		19. Informant's Name/Relationship (Type, Print) Hazel E. McCray		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 2 Box 292, Frankford, Del. 19945	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Antioch Cemetery		20c. Location - City or Town, State Frankford, Delaware		20d. Date 6/21/97	
	21. Signature of Funeral Service Licensee <i>Richard T. Watson</i>		22. Name and Address of Facility Watson Funeral Home, Inc. Millsboro, Delaware		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Chronic Heart Failure Due to (or as a consequence of): b. ASCVD Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CA Prostate	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	
	28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
	28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Gustavo A. Mestas</i>		29c. License number C1 0D00895	
	29d. Date signed (Month, Day, Year) 6/22/97		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Gustavo A. Mestas MD POB 626 Millsboro, DE 19966		31. Date filed (Month, Day, Year) JUN 20 1997		32. Registrar's Signature <i>John Davidson Randall</i>	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1. The first part of the report is devoted to a general survey of the situation in the country. It is followed by a detailed analysis of the economic situation, which shows a steady decline in the standard of living of the population.

2. The second part of the report is devoted to a detailed analysis of the economic situation. It shows a steady decline in the standard of living of the population, which is due to a number of factors, including the lack of investment in the economy and the high level of inflation.

3. The third part of the report is devoted to a detailed analysis of the economic situation. It shows a steady decline in the standard of living of the population, which is due to a number of factors, including the lack of investment in the economy and the high level of inflation.

4. The fourth part of the report is devoted to a detailed analysis of the economic situation. It shows a steady decline in the standard of living of the population, which is due to a number of factors, including the lack of investment in the economy and the high level of inflation.

5. The fifth part of the report is devoted to a detailed analysis of the economic situation. It shows a steady decline in the standard of living of the population, which is due to a number of factors, including the lack of investment in the economy and the high level of inflation.



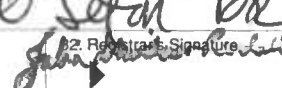
6. The sixth part of the report is devoted to a detailed analysis of the economic situation. It shows a steady decline in the standard of living of the population, which is due to a number of factors, including the lack of investment in the economy and the high level of inflation.

7. The seventh part of the report is devoted to a detailed analysis of the economic situation. It shows a steady decline in the standard of living of the population, which is due to a number of factors, including the lack of investment in the economy and the high level of inflation.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 21298**
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DOROTHY MURRAY MARTIN				2. Date of Death JUNE 29, 1997 Year		3. Time of Death 1455	
	4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital				4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany	
Funeral Director	5. Social Security Number 215-20-6609		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 09-Sep-25	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Allegany		10c. City, Town or Location Frostburg		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 18500 Martin Run Road, S.W.				10f. Zip Code 21532-		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Publisher		16b. Kind of Business/Industry Newspaper Publisher		
17. Father's Name (First, Middle, Last) James C. Murray				18. Mother's Name (First, Middle, Maiden Surname) Annie MacMillan				
19a. Informant's Name/Relationship (Type, Print) John M. Martin Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18505 Martin Run Road, S.W. Frostburg Maryland 21532-				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Savage Methodist Cemetery		Date 01-Jul-97		20c. Location - City or Town, State Mount Savage, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532				
23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Encephalitis Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 1 month								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number D26333		29d. Date signed (Month, Day, Year) JUNE 30 1997		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 900 Stefan Dr. Cumb. Md 21502								
31. Date filed (Month, Day, Year) JUL 01 1997				32. Registrar's Signature 				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

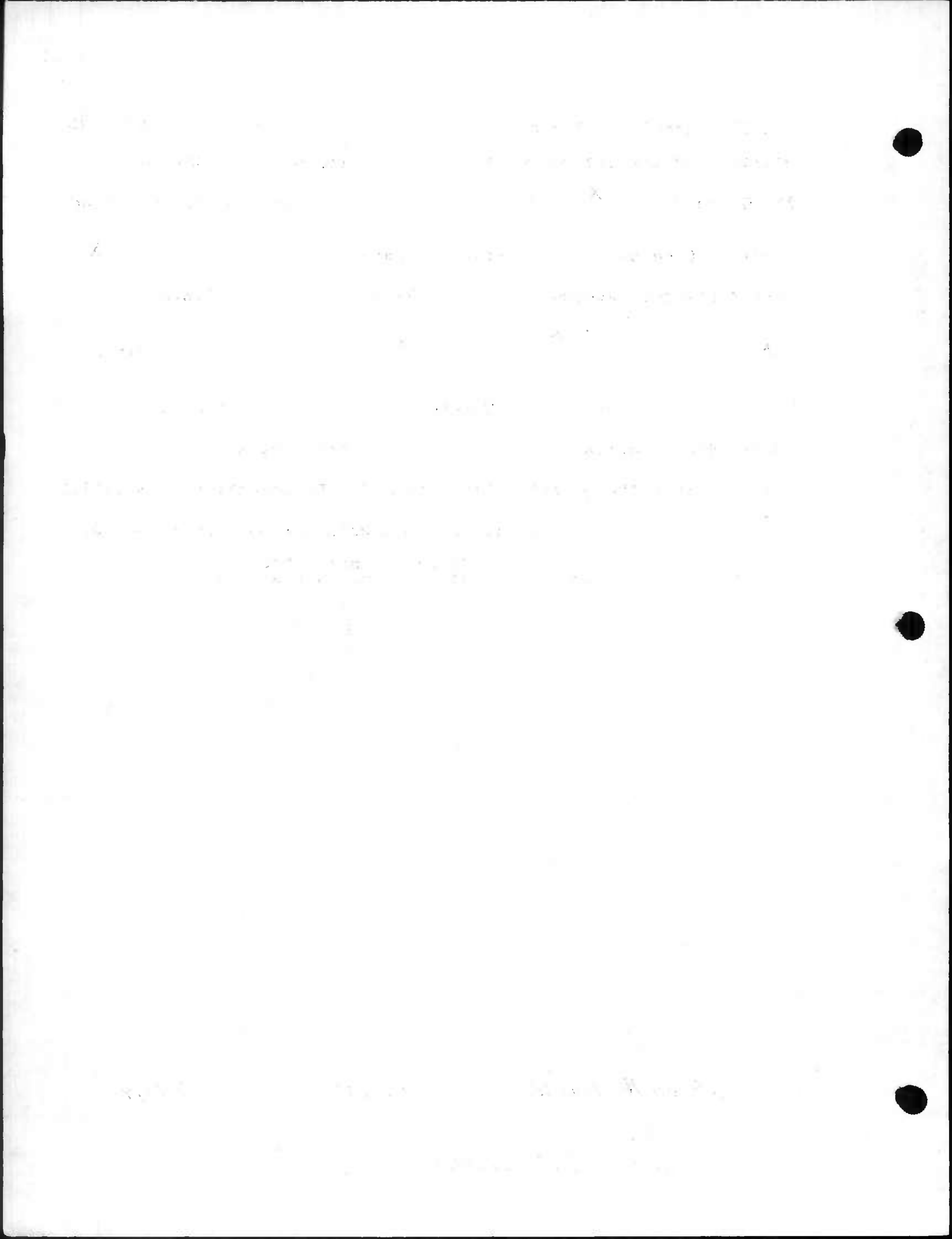
State of Maryland / Department of Health and Mental Hygiene

97 21299

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lelia Naomi Maddox				2. Date of Death Month June Day 27 Year 1997				3. Time of Death 1200			
	4e. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY				4c. County of Death WICOMICO			
Funeral Director	5. Social Security Number 219-03-4493		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 16 1921		9. Birthplace (State or Foreign Country) Maryland			
	10a. State Maryland				10b. County Somerset		10c. City, Town or Location Princess Anne				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 11158 Somerset Avenue				10f. Zip Code 21853				10g. Citizen of What Country? U.S.A			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+) 5+				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher				16b. Kind of Business/Industry None			
	17. Father's Name (First, Middle, Last) David Frank Collins				18. Mother's Name (First, Middle, Maiden Surname) Pearl Curtis							
To Be Completed by Physician/Medical Examiner	19. Informant's Name/Relationship (Type, Print) Wanda Turner (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4310 Mary Ridge DR. Randallstown, Md. 21133							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. James U.M. Church Cem.		20c. Location - City or Town, State Westover, Md.		21. Signature of Funeral Service Licensee Hladys B. Stewart		22. Name and Address of Facility Stewart Funeral Home 821 West Rd. Salisbury, Md. 21801			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Cardiac Arrest Due to (or as a consequence of): b. Acute Myocardial Infarction (Suggest) Due to (or as a consequence of): c. ASCVD Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death MIN MIN YRS			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Shirley M. Hunt MD				29c. License number 810688			
	29d. Date signed (Month, Day, Year) 6/27/98				30. Name and address of person who completed cause of death (Item 23e) (Type, Print) PRM C							
State Registrar	31. Date filed (Month, Day, Year) JUN 30 1997				32. Registrar's Signature John Anderson Randall							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21300

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MILDRED M. MANNO				2. Date of Death Month Day Year June 18 1997		3. Time of Death 1000			
	4a. Facility Name (If not Institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO			
Funeral Director	5. Social Security Number 176-16-6930	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) AUG. 15, 1919	9. Birthplace (State or Foreign Country) PA.			
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD.	10b. County WICOMICO	10c. City, Town or Location EDEN			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	10e. Street and Number 3709 GARDENDALE DRIVE			10f. Zip Code 21822		10g. Citizen of What Country? U.S.A.				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE		16b. Kind of Business/Industry OWN HOME				
	17. Father's Name (First, Middle, Last) PHILIP SMITH				18. Mother's Name (First, Middle, Maiden Surname) AGNES GARVEY					
	19a. Informant's Name/Relationship (Type, Print) JUDITH A. GIUNTA				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3709 GARDENDALE DR., EDEN, MARYLAND 21822					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ST. CATHERINE CEMETERY		20c. Location - City or Town, State MOSCOW, PA.					
	21. Signature of Funeral Service Licensee <i>Sherald C. Bounds</i>				22. Name and Address of Facility BOUNDS FUNERAL HOME, 705 E. MAIN ST., SALISBURY, MD. 21804					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Atherosclerotic coronary artery disease</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Congestive heart failure</i> <i>Pneumonia</i>								Approximate Interval Between Onset and Death years	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)				27b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Steph Pavlos MD</i>		29c. License number D 41721		29d. Date signed (Month, Day, Year) 06/18/97		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Steph Pavlos 560 Riverside Dr. Salisbury Md 21801</i>										
31. Date filed (Month, Day, Year) JUN 19 1997				32. Registrar's Signature <i>John Davidson Radell</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21301

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Nell Jean Morley				2. Date of Death Month: July Day: 2 Year: 1997				3. Time of Death 12:02 AM						
	4a. Facility Name (If not Institution, give street and number) 14506 North Bel Air Drive				4b. City, Town, or Location of Death Bel Air				4c. County of Death Allegany						
Funeral Director	5. Social Security Number 216-22-6010		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 70 Yrs.		8. Date of Birth (Month, Day, Year) 30-Mar-27		9. Birthplace (State or Foreign Country) Maryland						
	Usual Residence of Decedent														
To Be Completed by Funeral Director	10a. State Maryland		10b. County Allegany		10c. City, Town or Location Bel Air				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	10e. Street and Number 14506 North Bel Air Drive				10f. Zip Code 21502-		10g. Citizen of What Country? U.S.A.								
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Homemaker							
	17. Father's Name (First, Middle, Last) William "Gus" Sweitzer				18. Mother's Name (First, Middle, Maiden Surname) Bernadette Rooney										
	19a. Informant's Name/Relationship (Type, Print) John W. Morley Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 802 Roxbury Avenue Cumberland Maryland 21502-										
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Frostburg Memorial Park		20c. Location - City or Town, State 05-Jul-97 Frostburg, Maryland								
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532										
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.														
	<table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td>a. Bowel obstruction</td> <td rowspan="4"> Approximate Interval Between Onset and Death 6 weeks </td> </tr> <tr> <td>b. Metastatic Ca of Pancreas</td> </tr> <tr> <td>c. severe cachexia</td> </tr> <tr> <td>d. </td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. Bowel obstruction	Approximate Interval Between Onset and Death 6 weeks	b. Metastatic Ca of Pancreas	c. severe cachexia
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. Bowel obstruction	Approximate Interval Between Onset and Death 6 weeks													
	b. Metastatic Ca of Pancreas														
	c. severe cachexia														
	d.														
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ca of ovaries															
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown															
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No															
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No															
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No															
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)															
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide															
28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)															
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. Signature and title of certifier 															
29c. License number D-17526															
29d. Date signed (Month, Day, Year) July 3 - 1997															
30. Name and address of person who completed cause of death (Item 29a) (Type, Print) John N. Mehanna, M.D., 902 Selon Drive, Cumberland, Maryland 21502															
31. Date filed (Month, Day, Year) JUL 03 1997															
32. Registrar's Signature 															

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

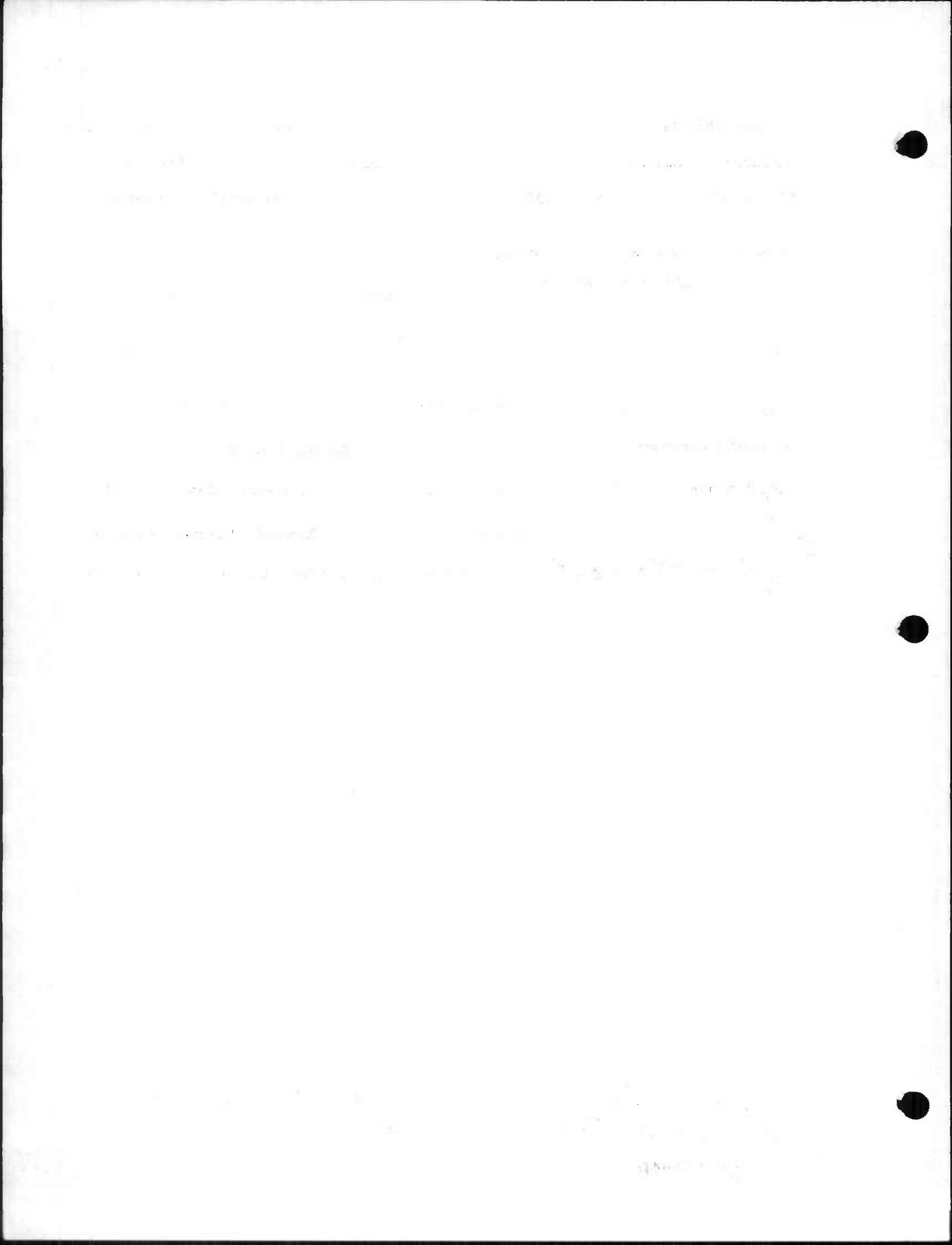
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 21302**
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Volodimir N/M/N Nalborczyk				2. Date of Death Month July Day 2 Year 1997		3. Time of Death 5:00a.m.	
	4e. Facility Name (If not institution, give street and number) 7850 Port Tobacco Road				4b. City, Town, or Location of Death Port Tobacco		4c. County of Death Charles	
Funeral Director	5. Social Security Number 212-62-0327		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 44 Yrs.		8. Date of Birth (Month, Day, Year) FEB. 29, 1952	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MARYLAND		10b. County CHARLES		10c. City, Town or Location PORT TOBACCO	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number BOX 7850 PORT TOBACCO ROAD		10f. Zip Code 20677		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10TH College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CARPENTER		16b. Kind of Business/Industry SELF EMPLOYED				
17. Father's Name (First, Middle, Last) STEPHAN NALBORCZYK				18. Mother's Name (First, Middle, Maiden Surname) MARIA KARMACIK				
19a. Informant's Name/Relationship (Type, Print) AGNES L. NALBORCZYK				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS #10				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ST. IGNATIUS CH. CEMETERY 7-5-97		20c. Location - City or Town, State PORT TOBACCO MARYLAND				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility RAYMOND FUNERAL SERVICE LA PLATA, MARYLAND 20646				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause for each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Colon Cancer with metastasis to liver & lungs Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number D28352		29d. Date signed (Month, Day, Year) July 2, 1997		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Krishan Mathur, M.D. - P. O. Box 2729, La Plata, MD 20646								
31. Date filed (Month, Day, Year) JUL 03 1997		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

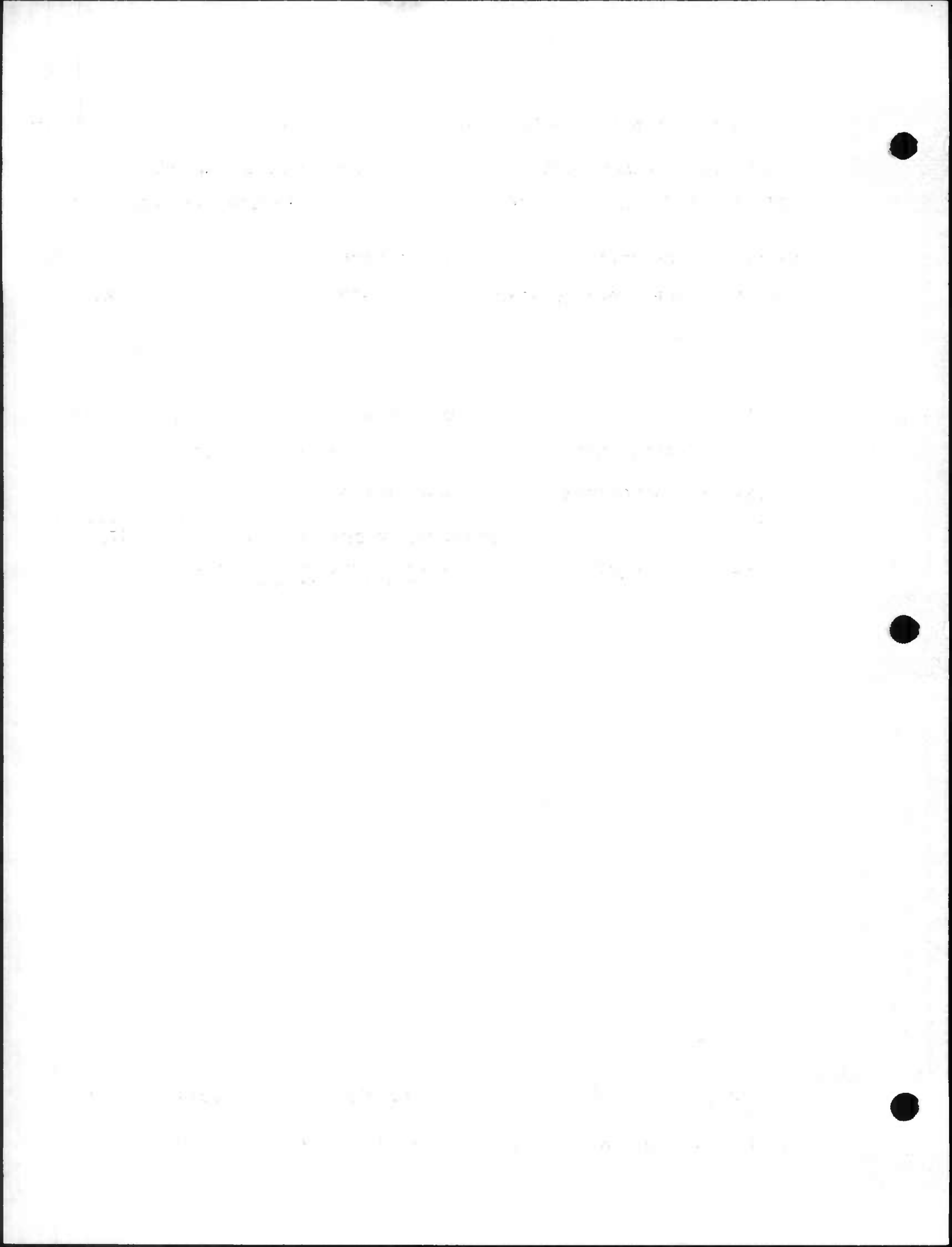
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21303

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Alice E. Newman</i>				2. Date of Death Month <i>June</i> Day <i>28</i> Year <i>1997</i>		3. Time of Death <i>5:15 A.M.</i>	
	4a. Facility Name (If not institution, give street and number) <i>Cumberland Nursing Home</i>				4b. City, Town, or Location of Death <i>Cumberland</i>		4c. County of Death <i>Allegheny</i>	
Funeral Director	5. Social Security Number <i>215-20-6937</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>89</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>Oct. 3, 1907</i>	9. Birthplace (State or Foreign Country) <i>Maryland</i>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <i>Maryland</i>	10b. County <i>Allegheny</i>	10c. City, Town or Location <i>Cumberland</i>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <i>175 N. Mechanic St. Apts. J.F.K.</i>			10f. Zip Code <i>21502</i>		10g. Citizen of What Country? <i>USA</i>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>clerk</i>		16b. Kind of Business/Industry <i>Sales</i>			
	17. Father's Name (First, Middle, Last) <i>Harry Vance Males</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Annie Powell</i>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <i>June Ashby / Niece</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>416 Pine Ave, Cumberland, Md, 21502</i>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Sunset Memorial Park</i>		Date <i>July 2, 1997</i>	20c. Location - City or Town, State <i>Cumberland, Md.</i>		
	21. Signature of Funeral Service Licensee <i>Ernest A. Riley, Jr.</i>				22. Name and Address of Facility <i>Leasure-stein, Inc, 230 Baltimore Ave, Cumberland, Md, 21502</i>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. Metastatic colon Carcinoma</i>							Approximate Interval Between Onset and Death <i>1 Year</i>
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>b. Due to (or as a consequence of):</i> <i>c. Due to (or as a consequence of):</i> <i>d. Due to (or as a consequence of):</i>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <i>033280</i>		29d. Date signed (Month, Day, Year) <i>June 28, 1997</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Sunil K. Gupta, M.D. 625 Kent Ave, Cumberland, Md, 21502</i>								
31. Date filed (Month, Day, Year) <i>JUL 01 1997</i>				32. Registrar's Signature <i>[Signature]</i>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21304

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedant's Name (First, Middle, Last)

PAIGE

ELLEN

NOVAK

2. Date of Death

Month
JuneDay
27Year
1997

3. Time of Death

9:55 AM

4a. Facility Name (If not institution, give street and number)

Doctors Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince Georges

Funeral
Director

5. Social Security Number

216-36-6549

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
05-19-1920

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

GLEN BURNIE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

316 6TH AVENUE N.E.

10f. Zip Code

21061

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (14 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CLERICAL

16b. Kind of Business/Industry

D.M.V.

17. Father's Name (First, Middle, Last)

GEORGE WASHINGTON TAYLOR

18. Mother's Name (First, Middle, Maiden Surname)

LAURA MAE CORVIN

19a. Informant's Name/Relationship (Type, Print)

DORIS AILEEN SHEER (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

290 BOWIE SHOP ROAD, HUNTINGTOWN, MARYLAND 20639

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GLEN HAVEN MEMORIAL PARK 6/30/97

Date

20c. Location - City or Town, State

GLEN BURNIE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility
SINGLETON FUNERAL HOME

1 SECOND AVE. S.W., GLEN BURNIE, MARYLAND 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Septicemia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

14 days

b.

Pneumonia

Due to (or as a consequence of):

15 days

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D16410

29d. Date signed (Month, Day, Year)

June 27, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gabriel Jaffe, MD 7500 Hanover Parkway, Suite 105, Greenbelt, MD 20770

31. Date filed (Month, Day, Year)

JUL 01 1997

32. Registrar's Signature

State
Registrar

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21305

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Julia Maxine Oliphant						2. Date of Death Month Day Year June 28, 1997		3. Time of Death 8:40 PM	
	4a. Facility Name (If not institution, give street and number) 6945 E. New Market, Elwood Rd.						4b. City, Town, or Location of Death Hurlock		4c. County of Death Dorchester	
Funeral Director	5. Social Security Number 422-14-2487		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) July 28, 1922		9. Birthplace (State or Foreign Country) Miss.	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Md.		10b. County Dorchester		10c. City, Town or Location Hurlock				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 6945 E. New Market Elwood Road				10f. Zip Code 21643		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Home			
	17. Father's Name (First, Middle, Last) Odin M. McCutchen						18. Mother's Name (First, Middle, Maiden Surname) Cora Belle McNeal McCutchen			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Robert L. White, Jr.; Friend				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6945 E. New Market, Hurlock, Md. 21643					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Stephens Cemetery		Date 7-1-97		20c. Location - City or Town, State Delmar, De.			
	21. Signature of Funeral Service Licensee Holly Short - Hannigan				22. Name and Address of Facility Short Funeral Home, Inc. 13 E. Grove St. Delmar, De. 19940					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Bronchiogenic CA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 6-28-97		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred Expired	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier [Signature]				29c. License number C10001675			29d. Date signed (Month, Day, Year) 6/30/97		
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MARK J. GRANADA MD									
31. Date filed (Month, Day, Year) 6/30 JUN 30 1997		32. Registrar's Signature John Davidson Randall								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21306

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) ANDREW PATTERSON PALMER				2. Date of Death Month 06 Day 17 Year 97		3. Time of Death 1015	
4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO	
5. Social Security Number 218-27-4499		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 7 Yrs.		8. Date of Birth (Month, Day, Year) 01-08-90	
9. Birthplace (State or Foreign Country) Maryland							
10a. State Maryland		10b. County Wicomico		10c. City, Town or Location Allen		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 25505 Collins Wharf Rd.				10f. Zip Code 21810		10g. Citizen of What Country? USA	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 College (1-4or 5+) -				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Student		16b. Kind of Business/Industry	
17. Father's Name (First, Middle, Last) Mark Patterson Palmer				18. Mother's Name (First, Middle, Maiden Surname) Sarah Elizabeth Fiddler			
19a. Informant's Name/Relationship (Type, Print) Mark P. Palmer/Father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25505 Collins Wharf Rd., P.O. Box 43, Allen, MD 21810			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Allen Cemetery		Date 6/20/97		20c. Location - City or Town, State Allen, MD	
21. Signature of Funeral Service Licensee  MO1051				22. Name and Address of Facility Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. ASPHYXIATION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 06-17-97		28b. Time of Injury 0930 M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify) 3311 ALLEN RD		28d. Describe how injury occurred ROTATING SWING ENTANGLED CORD ON ROPE 28f. Location (Street and Number or Rural Route Number, City or Town, State) ALLEN MD			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  D.M.E.		29c. License number D03599		29d. Date signed (Month, Day, Year) 06-17-97	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN T. BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY MD 21801							
31. Date filed (Month, Day, Year) JUN 19 1997				32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

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State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21307

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIE PALMORE				2. Date of Death Month 6 Day 30 Year 97		3. Time of Death 10:13 AM	
	4a. Facility Name (If not institution, give street and number) DGH, Cambridge				4b. City, Town, or Location of Death Cambridge, MD		4c. County of Death Dorchester	
Funeral Director	5. Social Security Number 263-03-7588	6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 1-6-05	9. Birthplace (State or Foreign Country) AL	
	Usual Residence of Decedent							
10a. State Maryland		10b. County Dorchester		10c. City, Town or Location 704 Cornish Drive Cambridge			10d. Inside City Limits 1 Yes 2 No	
10e. Street and Number 704 Cornish Drive				10f. Zip Code 21613		10g. Citizen of What Country? USA		
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3rd College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer		16b. Kind of Business/Industry Farming		
17. Father's Name (First, Middle, Last) Unknown				18. Mother's Name (First, Middle, Maiden Surname) Unknown				
19a. Informant's Name/Relationship (Type, Print) Mary Palmore (wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 704 Cornish Drive, Cambridge, Maryland 21613				
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CAPITOL CREMATORY		Date 7/3/97		20c. Location - City or Town, State DOVER, DEL		
21. Signature of Funeral Service Licensee Phyllis Prince				22. Name and Address of Facility Bennie Smith Funeral Home P.O. Box 1687, Easton, Maryland 21601				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ventricular aneurysm Due to (or as a consequence of): b. COPD (chronic obstructive pulmonary disease) Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Chronic Atrial Fibrillation Pneumonia								
Approximate Interval Between Onset and Death 25 months Many years								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Atrial Fibrillation Pneumonia						23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown		
24a. Was an autopsy performed? 1 Yes 2 No						24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No		
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify)						
27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier M.D.				29c. License number D-47520		29d. Date signed (Month, Day, Year) 6/30/97		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) HAMID BURNEY, M.D., 10 AURORA STREET, CAMBRIDGE, MD 21613								
31. Date filed (Month, Day, Year) JUL - 3 1997				32. Registrar's Signature [Signature]				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21309

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GEORGE EDWARD POLLEK			2. Date of Death Month June Day 27 Year 1997		3. Time of Death 2059		
	4e. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER			4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO		
Funeral Director	5. Social Security Number 204-28-5188		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 59 Yrs.		8. Date of Birth (Month, Day, Year) March 13, 1938	
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State Maryland		10b. County Wicomico		10c. City, Town or Location Eden	
To Be Completed by Funeral Director	10e. Street and Number 14533 jackson Blvd.		10f. Zip Code 21822		10g. Citizen of What Country? USA		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Marines		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) -		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance		16b. Kind of Business/Industry Dresser Wayne Co.		17. Father's Name (First, Middle, Last) Unknown	
	18. Mother's Name (First, Middle, Maiden Surname) Alice James		19a. Informant's Name/Relationship (Type, Print) Audrey Ella Pollek/Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 56, Eden, MD 21822		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
Physician /Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory		20c. Date 6/28/97		20d. Location - City or Town, State Salisbury, MD		21. Signature of Funeral Service Licensee 	
	22. Name and Address of Facility Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Severe CVD		23b. Due to (or as a consequence of): Dilated cardiomyopathy		Approximate Interval Between Onset and Death 2 yr	
To Be Completed by Physician/Medical Examiner	23c. Due to (or as a consequence of): arterial regurgitation		23d. Due to (or as a consequence of):		23e. Due to (or as a consequence of):		Approximate Interval Between Onset and Death 3 yr	
	23f. Due to (or as a consequence of):		23g. Due to (or as a consequence of):		23h. Due to (or as a consequence of):		Approximate Interval Between Onset and Death 6 mo	
To Be Completed by Physician/Medical Examiner	24. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		25. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		26. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		29. Piece of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		30. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		31. Date of Injury (Month, Day, Year) M	
To Be Completed by Physician/Medical Examiner	32. Time of Injury M		33. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		34. Describe how Injury occurred		35. Location (Street and Number or Rural Route Number, City or Town, State)	
	36. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)		37. Location (Street and Number or Rural Route Number, City or Town, State)		38. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		39. Signature and title of certifier 	
To Be Completed by Physician/Medical Examiner	40. License number D25207		41. Date signed (Month, Day, Year) 6/28/97		42. Name and address of person who completed cause of death (Item 23a) (Type, Print) John R. McLean M.D. 106 milford St. Salisbury, M.D.		43. Date filed (Month, Day, Year) JUL 01 1997	
	44. Registrar's Signature 		45. Registrar's Signature 		46. Registrar's Signature 		47. Registrar's Signature 	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21310

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GRACE J POPP				2. Date of Death Month Day Year 06 29 97		3. Time of Death 2130	
	4a. Facility Name (If not institution, give street and number) 106 WEST LONDON				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 214-10-7929		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		8. Date of Birth (Month, Day, Year) 09-28-06	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MD		10b. County WICOMICO		10c. City, Town or Location SALISBURY	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 106 WEST LONDON		10f. Zip Code 21801		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 YEARS		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SECRETARY		16b. Kind of Business/Industry UTILITY COMPANY				
17. Father's Name (First, Middle, Last) SAM JONES				18. Mother's Name (First, Middle, Maiden Surname) ETHEL HORNER				
19a. Informant's Name/Relationship (Type, Print) ELDON WILLING, JR. (COUSIN)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10652 TODDVILLE RD CHANCE MD 21816				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) PARSONS CEMETARY		20c. Location - City or Town, State 7-2-97 SALISBURY				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility BOUNDS FUNERAL HOME 705 E MAIN ST, SALISBURY MD 21804				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier  D.M.E.				29c. License number D03599		29d. Date signed (Month, Day, Year) 06-30-97		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN T. BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY, MD 21801								
31. Date filed (Month, Day, Year) JUL 01 1997				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Physician
/Medical
Examiner

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

6

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21311

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Russell Reese				2. Date of Death Month June Day 29 Year 1997		3. Time of Death 8:58 AM	
	4a. Facility Name (If not institution, give street and number) Genesis ElderCare - The Pines				4b. City, Town, or Location of Death Easton		4c. County of Death Talbot	
Funeral Director	5. Social Security Number 199-07-0866		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 59 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 12, 1937	
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State Maryland		10b. County Talbot		10c. City, Town or Location Easton	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 610 Dutchman's Lane		10f. Zip Code 21601		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer		16b. Kind of Business/Industry Agriculture			
	17. Father's Name (First, Middle, Last) Howard E. Reese				18. Mother's Name (First, Middle, Maiden Summa) Annie Trissler			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Sybil High/Step-daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22450 Indian Point Rd., Bozman, MD 21612			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Cremation Center LLC		Date 7/2		20c. Location - City or Town, State Chester, MD 21619	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>M. E. Reese</i>				22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home 200 S. Harrison St., Easton, MD 21601			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebrovascular accident Due to (or as a consequence of): b. Atherosclerosis, generalized Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Rheumatoid arthritis, severe				Approximate Interval Between Onset and Death weeks years			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Rheumatoid arthritis, severe				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>M. E. Reese MD</i>		29c. License number DZ5933		29d. Date signed (Month, Day, Year) 6.30.97	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (item 23a) (Type, Print) MICHAEL CROWLEY MD 508 TOLLWILD AVENUE EASTON, MD 21601							
	31. Date filed (Month, Day, Year) JUL - 2 1997				32. Registrar's Signature <i>[Signature]</i>			

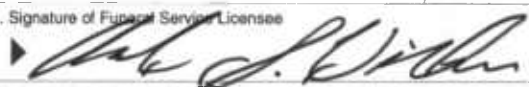


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21312

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Karl Benton Rector, Jr.				2. Date of Death Month Day Year June 28 1997		3. Time of Death 1:55AM	
	4a. Facility Name (If not institution, give street and number) 137 Lee Drive				4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 578-22-4337		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) Oct 11 1922	
	9. Birthplace (State or Foreign Country) Washington, D.C.		10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Annapolis	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street end Number 137 Lee Drive		10f. Zip Code 21403		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1943 If Yes, Give Year or Dates: 1946		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machinist		16b. Kind of Business/Industry Printing Plant				
17. Father's Name (First, Middle, Last) Karl Benton Rector, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Kate Mueller				
19a. Informant's Name/Relationship (Type, Print) Kent B. Rector (Son)				19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 137 Lee Drive Annapolis, Maryland 21403				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory, or other place) Lakemont Memorial Gardens		Date July 2, 1997		20c. Location - City or Town, State Davidsonville, MD		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401				
23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>e. Aspiration Pneumonia Due to (or as a consequence of):</p> <p>b. Parkinsonism / Dementia Due to (or as a consequence of):</p> <p>c. HYPERTENSION Due to (or as a consequence of):</p> <p>d. HYPERPARATHYROIDISM</p> </div> <div style="width: 15%; text-align: center;"> <p>4 wks</p> <p>3 yrs</p> <p>15 years</p> <p>5 years</p> </div> </div>								
23b. Pert 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Depression						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street end Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier  MD				29c. License number D31997		29d. Date signed (Month, Day, Year) June 30, 1997		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew G. Gordon, M.D. 2003 Medical Parkway Suite 100 Annapolis, Maryland 21401 (410-573-1110)								
31. Date filed (Month, Day, Year) JUL 01 1997		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

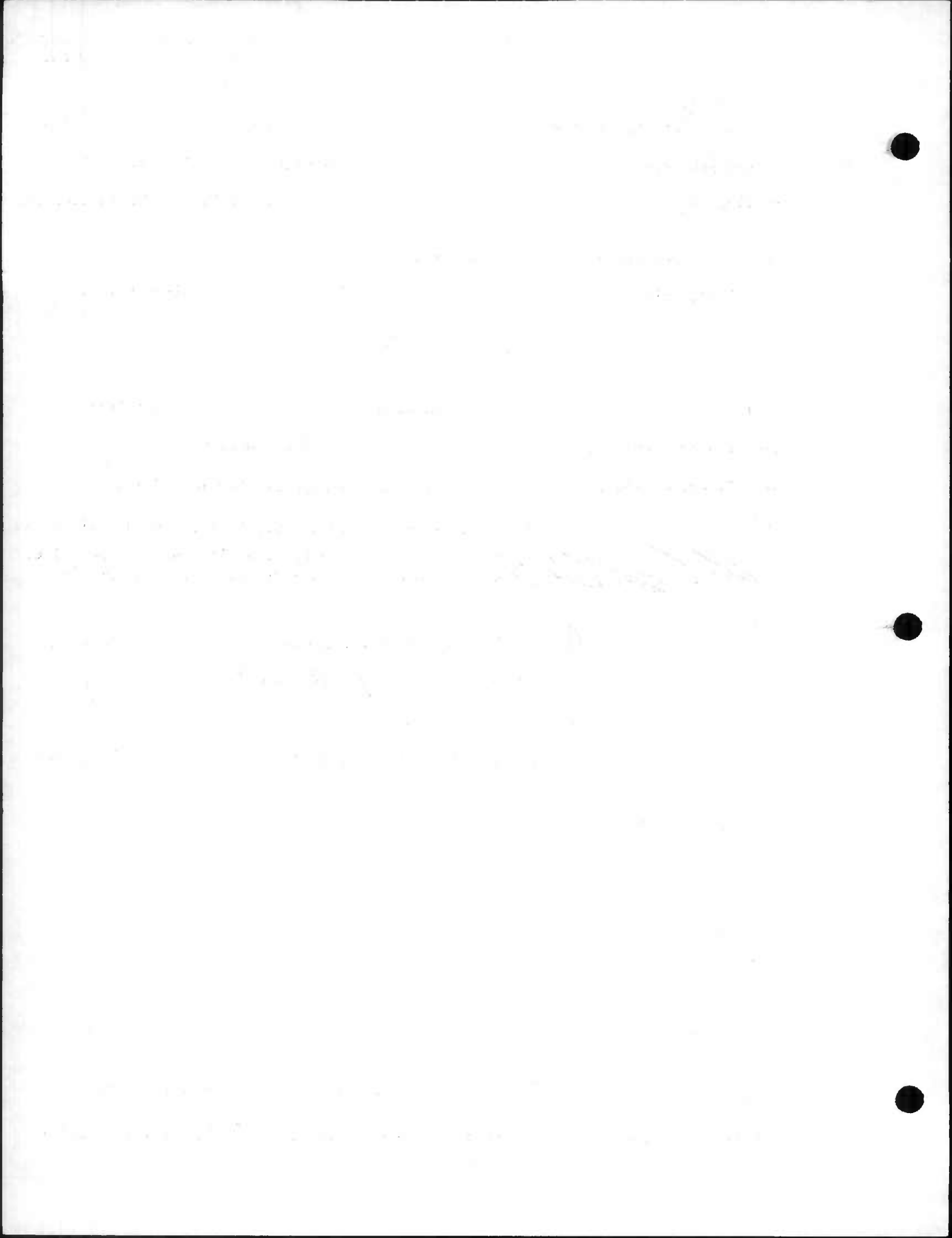
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 21313**

Certificate of Death

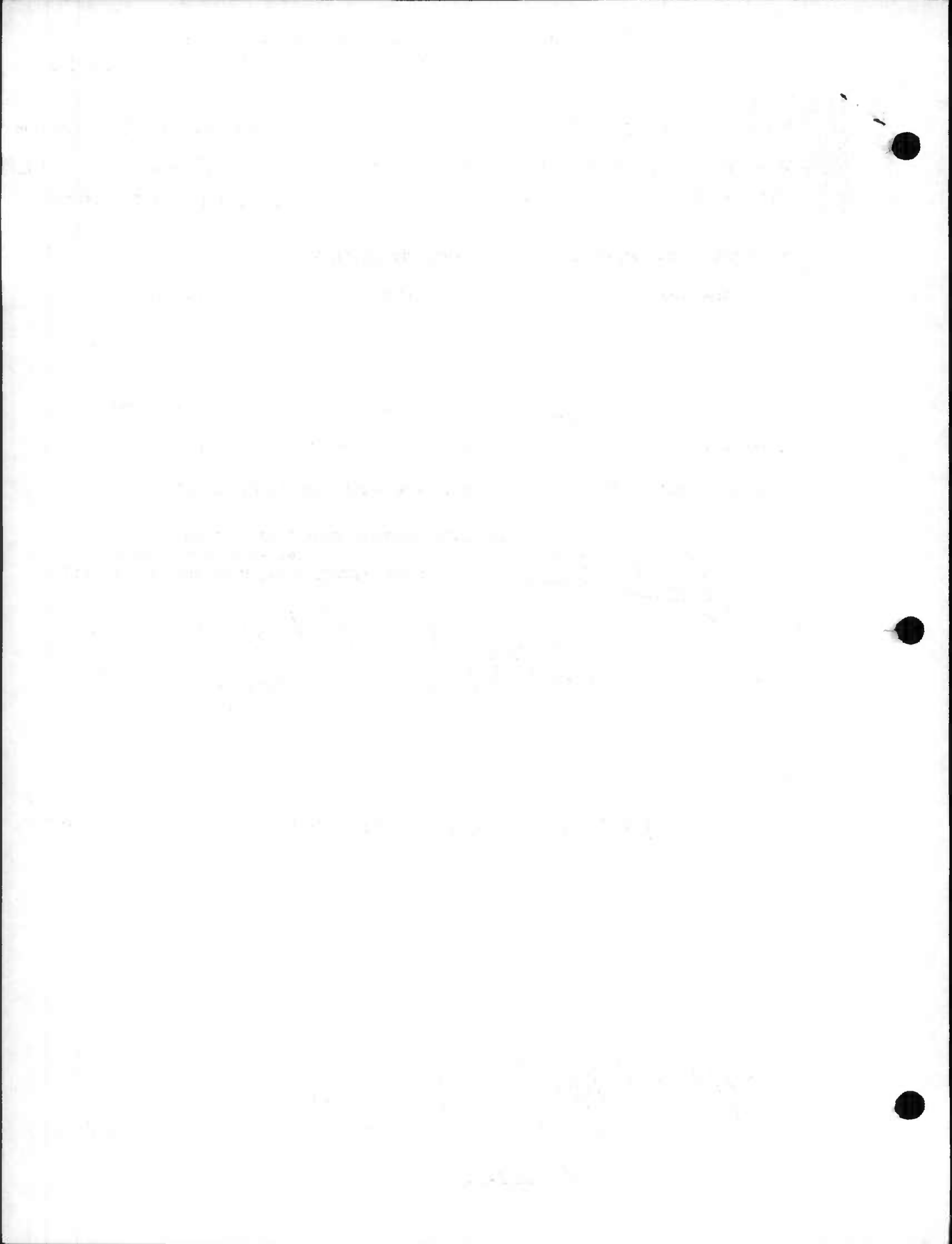
Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROBERT L. ROGERS, SENIOR				2. Date of Death Month July Day 2 Year 1997		3. Time of Death 5:50 A.M.	
	4e. Facility Name (If not institution, give street and number) NORTH ARUNDEL HOSPITAL				4b. City, Town, or Location of Death Glen Burnie		4c. County of Death ANNE ARUNDEL	
Funeral Director	5. Social Security Number 216-05-8101		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) 07-12-1916	
	9. Birthplace (State or Foreign Country) NORTH CAROLINA		10e. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location LINTHICUM HEIGHTS	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number 911 WANDA ROAD				10f. Zip Code 21090		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TRUCK DRIVER		16b. Kind of Business/Industry CAR CARRIER			
	17. Father's Name (First, Middle, Last) (UNKNOWN)				18. Mother's Name (First, Middle, Maiden Surname) MOLLY NEWSOME			
	19a. Informant's Name/Relationship (Type, Print) ROBERT L. ROGERS, JR.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2011 PARK DRIVE, PASADENA, MD. 21122			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GLEN HAVEN MEMORIAL PARK		20c. Date 7/5/97		20d. Location - City or Town, State GLEN BURNIE, MD.	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061			
	23a. Pertinent description of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Concurrent Heart Failure - Remains Alive Severe Chronic Coronaryopathy Heart							
	23b. Approximate Interval Between Onset and Death							
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. End Stage Pulmonary Fibrosis						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier 				29c. License number D 15860		29d. Date signed (Month, Day, Year) 7-2-97	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. Z. MERCURY, JR., 325 Hospital Drive, Glen Burnie Md 21061							
State Registrar	31. Date filed (Month, Day, Year) JUL 03 1997				32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 21314**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

KATHERINE SCOTT

2. Date of Death

Month
6Day
28Year
1997

3. Time of Death

7:10 A.M.

4a. Facility Name (If not institution, give street and number)

SALISBURY CENTER:GENESIS ELDERCARE

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

234-62-6653

6. Sex

☐ M ☐ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Aug. 3, 1915

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

DE

10b. County

Sussex

10c. City, Town or Location

Delmar

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

403 Grove Street

10f. Zip Code

19940

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

18a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

George W. Matheny, Sr

18. Mother's Name (First, Middle, Maiden Surname)

Gypsy Bartley Matheny

19a. Informant's Name/Relationship (Type, Print)

Ann Gilmore/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

403 Grove Street Delmar, DE 19940

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State☐ Donation ☒ Other (Specify) Entombment

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Blue Ridge Cemetery

Date

7-2-97

20c. Location - City or Town, State

Beckley, WV

21. Signature of Funeral Service Licensee

Haley Short-Hannigan

22. Name and Address of Facility

Short Funeral Home, Inc.

13 East Grove St. Delmar, DE 19940

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Pneumonia - S pneumoniae*
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

year.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *coronary artery disease*
Due to (or as a consequence of):

year.

c. *asthma*
Due to (or as a consequence of):

year.

d. *breast*
Due to (or as a consequence of):

months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William H. Robins, M.D.

29c. License number

029349

29d. Date signed (Month, Day, Year)

6/28/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William H. Robins, M.D.

1104 Healthway Dr. Salisbury, MD

31. Date filed (Month, Day, Year)

JUN 30 1997

32. Registrar's Signature

John Andrew Radell

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21315
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES E STARCHER

2. Date of Death

JUNE 30 1997 2:15 PM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL Hospital

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

232-50-0662

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
4-5-1932

9. Birthplace (State or Foreign Country)

WEST VIRGINIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

SEVERN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1311 BERNI RUTH LANE

10f. Zip Code

21144

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1951-53

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12 YEARS

College (14 or 5+)

6 YEARS

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

TEACHER

16b. Kind of Business/Industry

ANNE ARUNDEL CO. SCHOOLS

17. Father's Name (First, Middle, Last)

CHESTER STARCHER

18. Mother's Name (First, Middle, Maiden Surname)

HILAH CAIN

19a. Informant's Name/Relationship (Type, Print)

HILDA V. STARCHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1311 BERNI RUTH LANE SEVERN, MARYLAND 21144

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

CHESAPEAKE CREMATORY INC.

Date

7-5-1997

20c. Location - City or Town, State

BELTSVILLE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SINGLETON FUNERAL HOME

1 SECOND AVE. GLEN BURNIE, MARYLAND 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

SEPTIC SHOCK

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

HOURS

b.

SEPTICEMIA

Due to (or as a consequence of):

DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c.

CANCER OF LUNG

Due to (or as a consequence of):

WEEKS

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D48002

29d. Date signed (Month, Day, Year)

JUNE 30 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OLUSEGUN OGUNFOWOLA, NORTH ARUNDEL HOSPITAL, GLEN BURNIE, MD

31. Date filed (Month, Day, Year)

JUL 03 1997

32. Registrar's Signature

Julia Durbin-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

97 21316

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ANNA SZPAK				2. DATE OF DEATH MONTH JUNE DAY 30 YEAR 97		3. TIME OF DEATH 14 10P	
4. SOCIAL SECURITY NUMBER 285-01-0095		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 98 YRS.		7. DATE OF BIRTH (Month, Day, Year) September 19, 1988	
9a. FACILITY NAME (If not institution, give street and number) 7814 Marrion Lane				9b. CITY, TOWN OR LOCATION OF DEATH Bethesda		9c. COUNTY OF DEATH Montgomery County	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery County		10c. CITY, TOWN OR LOCATION Bethesda		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 7814 Marrion Lane				10f. ZIP CODE 20814		10g. CITIZEN OF WHAT COUNTRY? United States of America	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) UNOBTAINABLE Bogunia				18. MOTHER'S NAME (First, Middle, Maiden Surname) UNOBTAINABLE			
19a. INFORMANT'S NAME (Type/Print) Cynthia Spak/ Grand-Daughter				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7814 Marrion Lane, Bethesda, Maryland 20814			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Calvary Cemetery		20c. LOCATION — City or Town, State 1997 Cleveland, Ohio			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE #M00690 <i>Howard W. Carson</i>				22. NAME AND ADDRESS OF FACILITY Tomon and Sons Funeral Home 4772 Pearl Road, Cleveland, Ohio 44109			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. MYOCARDIAL INFARCTION					Approximate Interval Between Onset and Death ACUTE
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Francis C. Mayle</i>				29c. LICENSE NUMBER D07099		29d. DATE SIGNED (Month, Day, Year) JUNE 30 97	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FRANCIS C. MAYLE 10215 FERNWOOD RD BETHESDA MD 20817							
31. DATE FILED (Month, Day, Year) JUL 03 1997		32. REGISTRAR'S SIGNATURE <i>Julia...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21317

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RUBY Z SZILAGYI				2. Date of Death Month Day Year JUNE 29, 1997		3. Time of Death 7:30 PM	
	4a. Facility Name (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSN				4b. City, Town, or Location of Death GLEN BURNIE		4c. County of Death ANNE ARUNDEL	
Funeral Director	5. Social Security Number 232-56-9275		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) 07-18-1924	
	9. Birthplace (State or Foreign Country) VIRGINIA		10e. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location GLEN BURNIE	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 130 DORCHESTER ROAD		10f. Zip Code 21060		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry OWN HOME			
	17. Father's Name (First, Middle, Last) JEREMIAH WILSON		18. Mother's Name (First, Middle, Maiden Surname) MARY McCREARY					
	19a. Informant's Name/Relationship (Type, Print) STEVE SANDOR SZILAGYI (HUSBAND)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 130 DORCHESTER ROAD, GLEN BURNIE, MD. 21060					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MEADOWRIDGE MEMORIAL PARK		20c. Location - City or Town, State 7/2/97 ELKRIDGE, MARYLAND			
	21. Signature of Funeral Service Licensee <i>Michael A. Sullivan</i>		22. Name and Address of Facility SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061					
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Renal Failure</i> Due to (or as a consequence of): b. <i>Nephrotic Syndrome</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Acute Myocardial Infarction</i> <i>Upper Gastrointestinal Bleeding</i> <i>Chronic Heart Failure</i>		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Michael A. Sullivan</i>		29c. License number D42668		29d. Date signed (Month, Day, Year) 6/30/97	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) PATRICIA ALLEN 203 Hospital Drive Suite 206 Glen Burnie, MD 21061		31. Date filed (Month, Day, Year) JUL 01 1997		32. Registrar's Signature <i>John Davidson-Randall</i>				

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21318

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Leroy H Smink III

2. Date of Death

Month

Day

3. Time of Death

Year 1997 2325

Funeral
Director

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical System

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

218-46-7575

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

50 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

06-04-1947

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10e. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

GLEN BURNIE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7561 B & A BOULEVARD

10f. Zip Code

21060

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
11College (1-4 or 5+)
N/A

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

PRESSMAN

16b. Kind of Business/Industry

PRINTING

17. Father's Name (First, Middle, Last)

LEROY HUME SMINK, JR.

18. Mother's Name (First, Middle, Maiden Surname)

VIVIAN PETERSON

19e. Informant's Name/Relationship (Type, Print)

FRANCES MARIE SMINK (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7561 B & A BOULEVARD, GLEN BURNIE, MD. 21060

20e. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHESAPEAKE CREMATORY, INC.

Date

7/1 1997

20c. Location - City or Town, State

BELTSVILLE, MD.

21. Signature of Funeral Service Licensee

Michael C. Zaffron

22. Name and Address of Facility

SINGLETON FUNERAL HOME,

1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Pulmonary Embolism
Due to (or as a consequence of):b. deep vein thrombosis
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD medical resident

29c. License number

P08653

29d. Date signed (Month, Day, Year)

June 27, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Chris Avelino 22 S. Greene St.

State Registrar

31. Date filed (Month, Day, Year)

JUL 01 1997

32. Registrar's Signature

Julia Davidson-Rodell

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21319

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOSEPH C. SMITH

2. Date of Death

Month Day Year
JUNE 30 1997

3. Time of Death

2:55 pm

4a. Facility Name (If not institution, give street and number)

1030 CHESAPEAKE HARBOUR DRIVE

4b. City, Town, or Location of Death

ANNAPOLIS

4c. County of Death

ANNE ARUNDEL

Funeral
Director

5. Social Security Number

214-05-2821

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

JULY 7 1917

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

ANNAPOLIS

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1030 CHESAPEAKE HARBOUR DRIVE

10f. Zip Code

21403

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

2 yrs.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

2 yrs.

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

SELF EMPLOYED

16b. Kind of Business/Industry

SMITH CHARTER BUS

SERVICE

17. Father's Name (First, Middle, Last)

ABRAHAM R. SMITH

18. Mother's Name (First, Middle, Maiden Surname)

ELIZABETH CARR

19a. Informant's Name/Relationship (Type, Print)

TERSHEIA SMITH (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1030 CHESAPEAKE HARBOUR DRIVE ANNAPOLIS, MD. 21403

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

ANNAPOLIS MEM. GARDENS

Date

7/3/97

20c. Location - City or Town, State

ANNAPOLIS, MD.

21. Signature of Funeral Service Licensee

Harry D. Reese

22. Name and Address of Facility

WM. REESE & SONS MORTUARY, P.A.

821 WEST ST. ANNAPOLIS, MD. 21401

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Cancer of Prostate

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Peter F. VerKouwen

29c. License number

D11653

29d. Date signed (Month, Day, Year)

July 1, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter F. VERKOUWEN, MD 2003 Med. Parkway, Annapolis

31. Date filed (Month, Day, Year)

JUL 02 1997

32. Registrar's Signature

Julia Davidson-Randall

MD 21401

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21320

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Reta M. Smelser				2. Date of Death Month June , Day 26 , Year 1997				3. Time of Death 1:14 a.m.			
	4a. Facility Name (If not institution, give street and number) Golden Crest Home 811 Fairfield Avenue				4b. City, Town, or Location of Death Westminster				4c. County of Death Carroll			
Funeral Director	5. Social Security Number 220-16-1773		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 96 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 8, 1900		9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State MD		10b. County Carroll		10c. City, Town or Location Westminster				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 811 Fairfield Ave.				10f. Zip Code 21157		10g. Citizen of What Country? United States					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) _____				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home				
	17. Father's Name (First, Middle, Last) George C. Morningstar				18. Mother's Name (First, Middle, Maiden Surname) Annie Bohn							
	19a. Informant's Name/Relationship (Type, Print) Hazel Bixler, Executor				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1601 Littlestown Pike, Westminster, MD 21158							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadow Branch Cemetery			20c. Location - City or Town, State Westminster, MD						
	21. Signature of Funeral Service Licensee Katherine Pridis - Switzer				22. Name and Address of Funeral Home Pratt's Funeral Home & Chapel 412 Washington Rd., Westminster, MD 21157							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. DEMENTIA, PROGRESSIVE Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____										Approximate Interval Between Onset and Death YEARS	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ARTERIOCLEROTIC HEART DISEASE CHRONIC ATRIAL FIBRILLATION ESSENTIAL HYPERTENSION										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined										28a. Date of Injury (Month, Day Year)		
28b. Time of Injury M										28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred										28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier Vincent J. Flocard Jr MD		
29c. License number DO1663										29d. Date signed (Month, Day, Year) 6/27/97		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VINCENT J. FLOCARD JR WESTMINSTER, MD 21157												
31. Date filed (Month, Day, Year) JUN 27 1997										32. Registrar's Signature John A. Bickler-Randall		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Amendment #s 106, 102,
7/1/97, N&S, Allegany County

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21321

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GERTRUDE JUNE SMILEY

2. Date of Death
Month Day Year

JUNE 28, 1997

3. Time of Death

7:10 PM

4a. Facility Name (If not institution, give street and number)

CUMBERLAND NURSING HOME

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

Funeral
Director

5. Social Security Number

214-05-7956

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

June 4, 1918

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10e. State

MD

10b. County

ALLEGANY

10c. City, Town or Location

CUMBERLAND

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

220 SOMERVILLE AVENUE, APT. 411

10f. Zip Code

21502

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

2

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

ASSISTANT

16b. Kind of Business/Industry

SHOE REPAIR

17. Father's Name (First, Middle, Last)

GOTLEIB FORSTER

18. Mother's Name (First, Middle, Maiden Surname)

PEARL PEEBLES

19e. Informant's Name/Relationship (Type, Print)

GEORGE FRED SMILEY/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12403 GRAMLICH ROAD, LAVALE, MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HILLCREST BURIAL PARK

Date

7/2/97

20c. Location - City or Town, State

CUMBERLAND, MD

21. Signature of Funeral Service Licensee

Shond A. Upchurch

22. Name and Address of Facility

GEORGE-UPCHURCH FUNERAL HOME, P.A.

202 GREENE STREET, CUMBERLAND, MD 21502

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. CORONARY ARTERY DISEASE

10 Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28e. Date of Injury

(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Shond A. Upchurch

29c. License number

D33280

29d. Date signed (Month, Day, Year)

June 29, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Sunil Gupta, M.D., -625 Kent Ave., Cumberland, MD 21502

31. Date filed (Month, Day, Year)

JUL 01 1997

32. Registrar's Signature

John H. ...

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21322

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ELEANOR Virginia

SNYDER

2. Date of Death

Month

Day

Year

June 25, 1997

3. Time of Death

8:10 am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Memorial Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

214-05-4535

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

June 19, 1910

9. Birthplace (State or Foreign)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

12811 Old Church Lane

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Retired

16b. Kind of Business/Industry

Crystal Laundry

17. Father's Name (First, Middle, Last)

Jacob L. Snyder

18. Mother's Name (First, Middle, Maiden Surname)

Ada (Evans)

19a. Informant's Name/Relationship (Type, Print)

Judy Snyder-daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12809 Old Church Lane Cumberland MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Hillcrest Memorial Park

Date

06/27

20c. Location - City or Town, State

Cumberland MD 21502

21. Signature of Funeral Service Licensee

James F. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home
Cumberland MD 2150223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

CEREBROVASCULAR ACCIDENT

Approximate
Interval Between
Onset and Death

8 DAYS

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acute tubular necrosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury et
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

William Lamm MD

29c. License number

D 25406

29d. Date signed (Month, Day, Year)

June 27, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. William Lamm-47 Virginia Avenue-Cumberland, MD 21502

31. Date filed (Month, Day, Year)

JUL 01 1997

32. Registrar's Signature

John A. H. H. H.

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jessica A. Stevens				2. Date of Death Month Day Year JUNE 30, 1997		3. Time of Death 4:34 PM	
	4a. Facility Name (If not institution, give street and number) FRANKLIN STREET- RAILROAD CROSSING				4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY	
Funeral Director	5. Social Security Number 216-94-2007		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 23 Yrs.		8. Date of Birth (Month, Day, Year) July 6, 1973	
	9. Birthplace (State or Foreign Country) South Carolina		10a. State Maryland		10b. County Allegany		10c. City, Town or Location Cumberland	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 325 Wills Creek Ave.		10f. Zip Code 21502		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 Collega (1-4 or 5+) 9		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) George R. Baker				18. Mother's Name (First, Middle, Maiden Surname) Deborah (Wherry)			
	19a. Informant's Name/Relationship (Type, Print) George R. Baker				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 722 Avondale Ave., Cumberland, MD 21502			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Memorial Park		20c. Date 7/3/97		20d. Location - City or Town, State Cumberland, MD	
	21. Signature of Funeral Service Licensee William S. Right				22. Name and Address of Facility Right Funeral Home 309-311 Decatur St., Cumberland, MD 21502			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Multiple Injuries Due to (or as a consequence of): a. _____ b. _____ c. _____ d. _____							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) RAILROAD TRACKS							
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 6/30/97		28b. Time of Injury 0434 AM		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred Subject struck by train		28e. Location (Street and Number or Rural Route Number, City or Town, State) Franklin Street Crossing Cumberland Maryland					
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier Theodore M. King				29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) JULY 1, 1997	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Theodore M. King 111 Penn Street, Baltimore, Maryland 21201							
	31. Date filed (Month, Day, Year) JUL 02 1997				32. Registrar's Signature John A. ...			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21324

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) NELLIE MAE SWARTZ				2. Date of Death Month JULY 1, Day 1997 Year				3. Time of Death 0015	
	4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital				4b. City, Town, or Location of Death Cumberland				4c. County of Death Allegany	
Funeral Director	5. Social Security Number 164-28-2618		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth Month 4, Day 6, Year 1910		9. Birthplace (State or Foreign Country) Hyndman, Pa.	
	10a. State Pa.				10b. County Bedford		10c. City, Town or Location Bedford			
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 124 W. Pitt St.				10f. Zip Code 15522	
	10g. Citizen of What Country? USA				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 4	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) School Teacher				16b. Kind of Business/Industry Elementary education				17. Father's Name (First, Middle, Last) Jasper Luman	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) Viola Eliazbeth Wolford				19e. Informant's Name/Relationship (Type, Print) Mrs. Frances Clapper				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Buffalo Mills, Pa. 15534	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Lybarger Lutheran Cem.				20c. Location - City or Town, State 7-3-97 RD #1 Buffalo Mills, Pa.	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Timothy A. Berkebile				22. Name and Address of Facility Timothy A. Berkebile Funeral Home, Inc. 214 S. Juliana St., Bedford, Pa. 15522				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ischemic Dilated Cardiomyopathy Due to (or as a consequence of): b. Myocardial infarction Due to (or as a consequence of): c. Due to (or as a consequence of): d.	
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year) M				28b. Time of Injury M				28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	29b. Signature and title of certifier Gregg C. Donaldson MD				29c. License number MD023894-E				29d. Date signed (Month, Day, Year) 7/1/97	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gregg C. Donaldson MD, Chestnut St., Hyndman, Pa. 15545				31. Date filed (Month, Day, Year) JUL 02 1997				32. Registrar's Signature John H. ...	
	33. Registrar's Signature									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21325

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jerry Lynn Smith				2. Date of Death Month June Day 28 Year 1997		3. Time of Death 11:45AM	
	4a. Facility Name (If not institution, give street and number) Memorial Hospital @ Easton				4b. City, Town, or Location of Death Easton		4c. County of Death Talbot	
Funeral Director	5. Social Security Number 239-50-3886		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 63 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 26, 1934	
	9. Birthplace (State or Foreign Country) North Carolina		10a. State MD		10b. County Talbot		10c. City, Town or Location Easton	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 6202 Waterloo Drive		10f. Zip Code 21601		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Plant manager		16b. Kind of Business/Industry Medical Equipment				
17. Father's Name (First, Middle, Last) Colie Wilson Smith				18. Mother's Name (First, Middle, Maiden Surname) Eula Mae Williams				
19a. Informant's Name/Relationship (Type, Print) Jean Burns Smith				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6202 Waterloo Drive, Easton, MD 21601				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Cremation Center L.L.C.		20c. Location - City or Town, State Stevensville, MD		20d. Date 6/30/97		
21. Signature of Funeral Service Licensee <i>William H. Wood, Jr.</i>		22. Name and Address of Facility Fellows, Helffenbein, & Newnam Funeral Home 200 South Harrison St. Easton, MD						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last a. Hepatic Failure Due to (or as a consequence of): b. Hepatic Duct Obstruction Due to (or as a consequence of): c. Metastatic Cancer to Porta Hepatis Due to (or as a consequence of): d. Carcinoma of Right Upper lung								
Approximate Interval Between Onset and Death 3 weeks 2 mos								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier William H. Wood, Jr. MD				29c. License number 1508715		29d. Date signed (Month, Day, Year) 6/28/97		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. William H. Wood, Jr. 506 Idlewild Ave., Easton, MD 21601								
31. Date filed (Month, Day, Year) JUL - 1 1997		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21326

Amended item # 5, WCHD 6/24/97 jr Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George T. Smith				2. Date of Death Month June Day 18 Year 1997				3. Time of Death 9:02 A.M.	
	4a. Facility Name (If not institution, give street and number) 2835 N. Salisbury Boulevard				4b. City, Town, or Location of Death Salisbury				4c. County of Death Wicomico	
Funeral Director	5. Social Security Number 214-225-36-5002		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 57 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 8, 1939		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent				10a. State MD		10b. County Wicomico		10c. City, Town or Location Salisbury	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 2835 N. Salisbury Boulevard		10f. Zip Code 21801		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Architect		16b. Kind of Business/Industry Architecture			
	17. Father's Name (First, Middle, Last) David Smith				18. Mother's Name (First, Middle, Maiden Surname) Florence Stemple Smith					
	19a. Informant's Name/Relationship (Type, Print) Janice Smith/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2835 N. Salisbury Blvd. Salisbury, MD 21801					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cambridge Crematory		20c. Location - City or Town, State Cambridge, Maryland					
	21. Signature of Funeral Service Licensee <i>Holly Short-Hammigan</i>				22. Name and Address of Facility Short Funeral Home, Inc. 13 E. Grove ST. Delmar, DE 19940					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive Heart Failure b. Myocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. d.								Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier <i>Benjamin H. Huggins</i>				29c. License number D30743		29d. Date signed (Month, Day, Year) 6/19/97			
12+ IVA	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 EASTERN SHORE Dr SALISBURY, MD 21804									
	31. Date filed (Month, Day, Year) JUN 24 1997		32. Registrar's Signature <i>Julia Davidson Randall</i>							
State Registrar										

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21327

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

RICKY O. VENERABLE

2. Date of Death

JUNE 28 1997

3. Time of Death

0322

4a. Facility Name (If not institution, give street and number)

ANNE ARUNDEL MEDICAL CENTER

4b. City, Town, or Location of Death

ANNAPOLIS

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

216-66-2755

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

41

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

NOV. 9 1955

9. Birthplace (State or Foreign Country)

NEW JERSEY

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

ANNAPOLIS

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1786 B BELLE DRIVE

10f. Zip Code

21401

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Navar Marriad 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates: 1972-74

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CUSTODIAL SUPERVISOR

16b. Kind of Business/Industry

SERVICE MASTER CHESAPEAKE

17. Father's Name (First, Middle, Last)

JAMES VENERABLE, JR.

18. Mother's Name (First, Middle, Maiden Surname)

VIOLA S. SMITH

19a. Informant's Name/Relationship (Type, Print)

KAREN ISAAC (SISTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8 ELLINGTON DRIVE ANNAPOLIS, MD. 21403

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MARYLAND VETERAN CEMETERY

Date

7/3/97

20c. Location - City or Town, State

CROWNSVILLE, MD..

21. Signature of Funeral Service Licensee

Larry B. Reese

22. Name and Address of Facility

WM. REESE & SONS MORTUARY, P.A.

821 WEST ST. ANNAPOLIS, MD. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. *intracerebral hemorrhage*

Due to (or as a consequence of):

hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *Accelerated hypertension*

Due to (or as a consequence of):

months

c. *end stage renal disease*

Due to (or as a consequence of):

1-2 yrs

d. *chronic glomerulonephritis*

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Illicit drug use, chronic

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOAOther: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Greg A. Mitchell

29c. License number

014758

29d. Date signed (Month, Day, Year)

6-29-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

205 Ridgely Ave. Anna. Md. 21401

31. Date filed (Month, Day, Year)

JUL 02 1997

32. Registrar's Signature

Julia Davidson

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21328

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BLANCHE ESTELLA VOISEY						2. Date of Death Month Day Year JUNE 29, 1997		3. Time of Death 8:15 PM							
	4a. Facility Name (If not institution, give street and number) CUMBERLAND NURSING HOME						4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY							
Funeral Director	5. Social Security Number 236-50-9374		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) July 10, 1911		9. Birthplace (State or Foreign Country) MARYLAND							
	Usual Residence of Decedent															
To Be Completed by Funeral Director	10a. State MD		10b. County ALLEGANY		10c. City, Town or Location CUMBERLAND				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No							
	10e. Street and Number #1 BALTIMORE STREET				10f. Zip Code 21502		10g. Citizen of What Country? U.S.A.									
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE								
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) _____				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SECRETARY			16b. Kind of Business/Industry WV DEPARTMENT OF NATURAL RESOURCES								
	17. Father's Name (First, Middle, Last) ROLAND RICHARD GILBERT						18. Mother's Name (First, Middle, Maiden Surname) LULU MAE SPRIGGS									
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) THOMAS G. VOISEY / SON						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 307 MCGILL DRIVE, CUMBERLAND, MD 21502									
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. OLIVET CEMETERY		Date 7/2/97		20c. Location - City or Town, State PARKERSBURG, WV									
	21. Signature of Funeral Service Licensee <i>George Upchurch</i>						22. Name and Address of Facility GEORGE-UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502									
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
	<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td rowspan="4"> { </td> <td>a. Aspiration pneumonia Due to (or as a consequence of):</td> <td rowspan="4"> Approximate Interval Between Onset and Death 5 days. 6 yrs </td> </tr> <tr> <td>b. CVA Due to (or as a consequence of):</td> </tr> <tr> <td>c. _____ Due to (or as a consequence of):</td> </tr> <tr> <td>d. _____ Due to (or as a consequence of):</td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	{	a. Aspiration pneumonia Due to (or as a consequence of):	Approximate Interval Between Onset and Death 5 days. 6 yrs	b. CVA Due to (or as a consequence of):	c. _____ Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	{	a. Aspiration pneumonia Due to (or as a consequence of):	Approximate Interval Between Onset and Death 5 days. 6 yrs													
		b. CVA Due to (or as a consequence of):														
		c. _____ Due to (or as a consequence of):														
		d. _____ Due to (or as a consequence of):														
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dehydration								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No														
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)														
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Peter B. Hazzmo</i>		29c. License number DO 4981		29d. Date signed (Month, Day, Year) July 1, 1997										
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) PETER B. HAZMO 302 Schley St. Cumberland, Md.																
31. Date (Month, Day, Year) JUL 01 1997		32. Registrar's Signature <i>John P. ...</i>														

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21329

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William John Van Wie, Jr.

2. Date of Death

Month
JuneDay
28Year
1997

3. Time of Death

12PM

4a. Facility Name (If not institution, give street and number)

1147 Hampton Road

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

055-26-2979

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

64

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan 12 1933

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1147 Hampton Road

10f. Zip Code

21401

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No 1952
If Yes, Give
Year or Dates: 197713. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Military/Retired

16b. Kind of Business/Industry

United States
Government

17. Father's Name (First, Middle, Last)

Dr. William J. Van Wie

18. Mother's Name (First, Middle, Maiden Surname)

Mary Isabelle McHugh

19a. Informant's Name/Relationship (Type, Print)

Fay Janice Van Wie (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1147 Hampton Road Annapolis, Maryland 21401

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Arlington National Cemetery July 10, 1997 Arlington, VA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility
John M. Taylor Funeral Home, Inc.
147 Duke of Gloucester St. Annapolis, MD 2140123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. METASTATIC CARCINOMA

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

6 months

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. LUNG CARCINOMA

Due to (or as a consequence of):

ONE YEAR

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
Investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-33153

29d. Date signed (Month, Day, Year)

June 30, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David Jaller, M.D. 706 Gidding Avenue Suite 1A Annapolis, Maryland 21401

31. Date filed (Month, Day, Year)

JUL 01 1997

32. Registrar's Signature

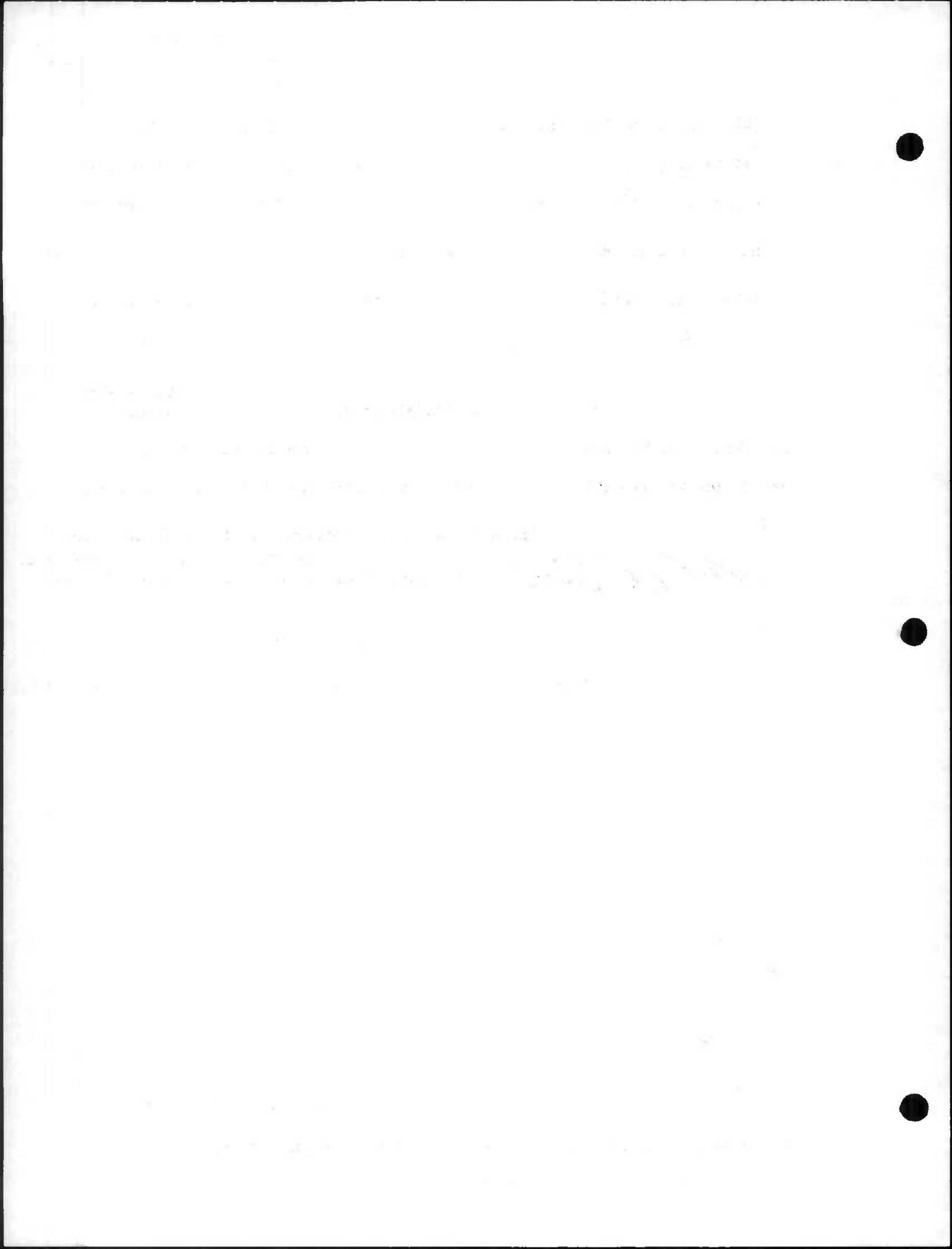
State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21330

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM HENRY WILLIAMS				2. Date of Death Month JUNE Day 29 Year 1997		3. Time of Death 8:30 AM																								
	4a. Facility Name (If not institution, give street and number) GENESIS ELDER CARE				4b. City, Town, or Location of Death SEVERNA PARK		4c. County of Death ANNE ARUNDEL																								
Funeral Director	5. Social Security Number 215-09-8693		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) 12-03-1915																								
	10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location LINTHICUM		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																								
To Be Completed by Funeral Director	10e. Street and Number 542 SHIPLEY ROAD				10f. Zip Code 21090		10g. Citizen of What Country? U.S.A.																								
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 43-46		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE																								
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (13-16) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) STOCK BUYER		16b. Kind of Business/Industry CATALOG SALES																										
	17. Father's Name (First, Middle, Last) WILLIAM RICHARD WILLIAMS				18. Mother's Name (First, Middle, Maiden Surname) ELLA DAUMAN																										
	19a. Informant's Name/Relationship (Type, Print) NANCY LEE WILLIAMS (DAUGHTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 542 SHIPLEY ROAD LINTHICUM, MARYLAND 21090																										
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MD VETERANS CEMETERY		20c. Date 07-02-97		20d. Location - City or Town, State CROWNSVILLE, MD																								
	21. Signature of Funeral Service Licensee <i>Richard C. Saffian</i>				22. Name and Address of Facility SINGLETON FUNERAL HOME, PA. 1 SECOND AVE, SW GLEN BURNIE, MARYLAND 21061																										
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																														
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Lung Mass</td> <td>Due to (or as a consequence of):</td> <td>3 months</td> </tr> <tr> <td>b. Cerebrovascular Thrombosis</td> <td>Due to (or as a consequence of):</td> <td>3 weeks</td> </tr> <tr> <td>c. Hypertensive Cardiovascular disease</td> <td>Due to (or as a consequence of):</td> <td>30 years</td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. Lung Mass	Due to (or as a consequence of):	3 months	b. Cerebrovascular Thrombosis	Due to (or as a consequence of):	3 weeks	c. Hypertensive Cardiovascular disease	Due to (or as a consequence of):	30 years	d.												
	Immediate Cause (Final disease or condition resulting in death)	a. Lung Mass	Due to (or as a consequence of):	3 months																											
b. Cerebrovascular Thrombosis		Due to (or as a consequence of):	3 weeks																												
c. Hypertensive Cardiovascular disease		Due to (or as a consequence of):	30 years																												
d.																															
<table border="1"> <tr> <td colspan="4">Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</td> <td colspan="4">23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown</td> </tr> <tr> <td colspan="4"></td> <td colspan="4">24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> </tr> <tr> <td colspan="4"></td> <td colspan="4">24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> </tr> </table>								Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																											
				24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																											
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																											
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																												
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																								
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred																										
			28f. Location (Street and Number or Rural Route Number, City or Town, State)																												
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																														
	29b. Signature and title of certifier <i>[Signature]</i> MD				29c. License number D17743		29d. Date signed (Month, Day, Year) 6/30/97																								
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) L. SEENIVASAN, MD, 606 HAMMONDS LANE, BALTO, MD, 21225																														
	31. Date filed (Month, Day, Year) JUL 01 1997		32. Registrar's Signature <i>[Signature]</i>																												

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21331
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WRIGHT, MARY N				2. Date of Death Month Day Year June 23 1997		3. Time of Death 16:37	
	4a. Facility Name (If not institution, give street and number) UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORE				4b. City, Town, or Location of Death		4c. County of Death	
Funeral Director	5. Social Security Number 256-54-8375	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 60 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) November 16, 1936	9. Birthplace (State or Foreign Country) Glennville, Georgia	
	Usual Residence of Decedent							
10a. State Florida		10b. County Marion County		10c. City, Town or Location Ocala			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 2625 N.E. 34th Street				10f. Zip Code 34470		10g. Citizen of What Country? United States of America		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waitress			16b. Kind of Business/Industry Food Service	
17. Father's Name (First, Middle, Last) Toy Cobb				18. Mother's Name (First, Middle, Maiden Surname) Sue Nell Rushing				
19a. Informant's Name/Relationship (Type, Print) Cynthia L. Brill /Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2678 N.E. 34th Street, Ocala, Florida 34470				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Good Shepherd Memorial Gardens		Date June 28 1997		20c. Location - City or Town, State Ocala, Marion County Florida		
21. Signature of Funeral Service Licensee #M00690 David A. Couser				22. Name and Address of Facility Jennings-Archway Funeral Home 34474 206 Southwest 10th Street, Ocala, Florida				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. hypoxia Due to (or as a consequence of): b. sclerodermia Due to (or as a consequence of): c. pulmonary hypertension Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 3 days 10 years 2 years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier J. Nazarian				29c. License number 28485		29d. Date signed (Month, Day, Year) June 23, 1997		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) J. NAZARIAN M.D. 22 S. GREENE ST. BALTIMORE, Maryland 21201								
31. Date filed (Month, Day, Year) JUL 02 1997		32. Registrar's Signature Julia Davidson-Randall						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21332

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William Ross West				2. Date of Death Month Day Year June 30 1997		3. Time of Death 3:00 am	
	4a. Facility Name (If not institution, give street and number) 305 West Haven Drive				4b. City, Town, or Location of Death Severna Park		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 215-64-3878		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 45 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 3, 1952	
	9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Severna Park	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 305 West Haven Drive		10f. Zip Code 21146		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineer		16b. Kind of Business/Industry Electronics Firm			
	17. Father's Name (First, Middle, Last) William T. West				18. Mother's Name (First, Middle, Maiden Surname) Martha C. Ross			
	19a. Informant's Name/Relationship (Type, Print) Karen L. West/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 305 West Haven Drive, Severna Park, MD 21146			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		20c. Location - City or Town, State Catonsville, MD		20d. Date 7/1/97	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Barranco & Sons P.A. Severna Park Funeral Home 495 Ritchie Hwy. Severna Park, MD 21146			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. <u>Metastatic Squamous Cell Carcinoma</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
Medical Certification: To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier 				29c. License number D50325		29d. Date signed (Month, Day, Year) June 30 1997	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elizabeth Claire Dees MD 600 North Wolfe Street Baltimore Maryland							
State Registrar	31. Date filed (Month, Day, Year) JUL 03 1997				32. Registrar's Signature 			

On 10/10/68, at 10:00 AM, the following information was received from the [illegible] office:

[illegible text block containing several lines of faint, mostly illegible text]

[illegible text block at the bottom of the page]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21333

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GEORGE A. WHITE

2. Date of Death

Month
JULY 2Day
1997

Year

3. Time of Death

6:25 am

4a. Facility Name (If not institution, give street and number)

MILLENNIUM HEALTH & REHAB CENTER

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

Funeral
Director

5. Social Security Number

217-07-5002

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

101 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

MARCH 5 1896

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

SEVERNA PARK

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3 WHITE ROAD

10f. Zip Code

21146

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

1yr.

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

MINISTER

16b. Kind of Business/Industry

UNITED METHODIST

17. Father's Name (First, Middle, Last)

CHARLES WHITE

18. Mother's Name (First, Middle, Maiden Surname)

ANNIE GILES

19a. Informant's Name/Relationship (Type, Print)

LILLIE MAE WHITE (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3 WHITE ROAD SEVERNA PARK, MARYLAND 21146

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

ASBURY TOWN NECK CEMETERY 7/8/97

Date

20c. Location - City or Town, State

SEVERNA PARK, MD.

21. Signature of Funeral Service Licensee

Harry D. Reese

22. Name and Address of Facility

WM. REESE & SONS MORTUARY, P.A.
821 WEST ST. ANNAPOLIS, MD. 2140123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Coronary Artery Disease

Approximate
Interval Between
Onset and Death

1 year

e. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pernicious Anemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Harjit Singh M.D.

29c. License number

D14160

29d. Date signed (Month, Day, Year)

07/02/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harjit Singh, M.D. 5410 -A Ritchie Highway Baltimore, Md. 21225

State
Registrar

31. Date filed (Month, Day, Year)

JUL 07 1997

32. Registrar's Signature

Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

97 21334

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ORLANDO VALENTIN WOOTTEN				2. DATE OF DEATH MONTH 6 DAY 27 YEAR 97		3. TIME OF DEATH 5:20 P M	
4. SOCIAL SECURITY NUMBER 218 30 22 89		5. SEX 1 M 2 F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10-22-09	
8. BIRTHPLACE (State or Foreign Country) DELAWARE				9a. FACILITY NAME (If not institution, give street and number) Carroll County General Hosp		9b. CITY, TOWN OR LOCATION OF DEATH Westminster	
9c. COUNTY OF DEATH Carroll				10a. STATE Maryland		10b. COUNTY Carroll	
10c. CITY, TOWN OR LOCATION Sykesville				10d. INSIDE CITY LIMITS? 1 YES 2 NO		10e. STREET AND NUMBER 710 Obrecht Road	
10f. ZIP CODE 21784				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: white				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 6			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PHOTOGRAPHER				16b. KIND OF BUSINESS/INDUSTRY PHOTOGRAPHY			
17. FATHER'S NAME (First, Middle, Last) Orlando V. Wootten, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) ANNA MAE STEVENSON			
19a. INFORMANT'S NAME (Type/Print) Mrs. Jean Wootten (Wife)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7200 Third Avenue Sykesville, MD 21784			
20a. METHOD OF DISPOSITION 1 Burial 2 <input checked="" type="checkbox"/> Cremation 3 Removal from State 4 Donation 5 Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE Carroll Cremation Serv. 6/30/97 Hampstead, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Brian A. Plaghton				22. NAME AND ADDRESS OF FACILITY HAIGHT FUNERAL HOME & CHAPEL (Box 195) Sykesville, MD 21784 (410)-795-1400			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Bilateral Pneumonia							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia Pernicious Anemia							
24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide				28a. DATE OF INJURY (Month, Day, Year) 6/30/97			
28b. TIME OF INJURY M				28c. INJURY AT WORK? 1 YES 2 NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER John D. Milto MD				29c. LICENSE NUMBER D34124			
29d. DATE SIGNED (Month, Day, Year) 6-29-97				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John D. Milto MD 7600 Oiler Dr #311 Towson, Md 21204			
31. DATE FILED (Month, Day, Year) JUN 30 1997				32. REGISTRAR'S SIGNATURE John A. Anderson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21335

Items: 23a part I, 27, 28a-f per MEO G-749 7/18/97 dh Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) THOMAS WAYNE WYATT
2. Date of Death Month Day Year JUNE 28, 1997
3. Time of Death 10:02 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number) UNION MEM. HOSPITAL
4b. City, Town, or Location of Death ELKTON
4c. County of Death CECIL

5. Social Security Number 220-88-4161
6. Sex ☒ M ☐ F
7. Age (In yrs. last birthday) 35 Yrs.
8. Date of Birth (Month, Day, Year) Sept. 26, 1961
9. Birthplace (State or Foreign Country) Elkton, MD

Usual Residence of Decedent
10a. State MD
10b. County TALBOT
10c. City, Town or Location EASTON
10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number 208 AUGUST STREET
10f. Zip Code 21601
10g. Citizen of What Country? U.S.A.

11. Marital Status ☐ Never Married ☒ Married ☐ Widowed ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 3
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Stock Person
16b. Kind of Business/Industry Grocery

17. Father's Name (First, Middle, Last) Kenneth Wyatt, Sr.
18. Mother's Name (First, Middle, Maiden Surname) unknown

19a. Informant's Name/Relationship (Type, Print) Catherine M. Wyatt
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 August St., Easton, MD 21601

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place) Springhill Cemetery
20c. Location - City or Town, State Easton, MD
Date 7/3/97

21. Signature of Funeral Service Licensee
22. Name and Address of Facility Fellows, Helfenbein, & Newnam Funeral Home
200 South Harrison St., Easton, MD 21601

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
23b. Did tobacco use contribute to the cause of death? ☐ Yes ☐ No ☐ Probably ☒ Unknown

Immediate Cause (Final disease or condition resulting in death)
a. PROPOXYPHENE INTOXICATION
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
23b. Did tobacco use contribute to the cause of death? ☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed? ☒ Yes ☐ No
24b. Were autopsy findings available prior to completion of cause of death? ☒ Yes ☐ No

25. Was case referred to medical examiner? ☒ Yes ☐ No
26. Place of Death (Check only one)
Hospital: ☐ Inpatient ☒ ER/Outpatient ☐ DOA
Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☒ Could not be determined
28a. Date of Injury (Month, Day, Year) found: 6/28/97
28b. Time of Injury found: 8:59
28c. Injury at Work? ☐ Yes ☒ No
28d. Describe how injury occurred unknown
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) at residence
28f. Location (Street and Number or Rural Route Number, City or Town, State) 21 Veasey Cove Road, Earlsville, Maryland

29a. Certifier (Check only one) ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number O.C.M.E.
29d. Date signed (Month, Day, Year) JUNE 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE M. KIRK 111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year) JUL - 1 1997
32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21336

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Stanley LINGO Williams SR				2. Date of Death Month 21 Day 1997 Year		3. Time of Death 10:55 PM	
	4a. Facility Name (If not institution, give street and number) Salisbury Center: Genesis Eldercare				4b. City, Town, or Location of Death Salisbury, MD		4c. County of Death Wicomico	
Funeral Director	5. Social Security Number 218-14-4313		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) October 2, 1920	
	10a. State Maryland		10b. County Wicomico		10c. City, Town or Location Salisbury		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 608 Terrapin Lane				10f. Zip Code 21804		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: Navy		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 Collegia (1-4 or 5+) -				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance Engineer		16b. Kind of Business/Industry Suburban Propane	
	17. Father's Name (First, Middle, Last) John A. Williams				18. Mother's Name (First, Middle, Maiden Surname) Emma Gibbons			
	19a. Informant's Name/Relationship (Type, Print) Frances M. Williams/wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 608 Terrapin Lane, Salisbury, MD 21804			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Evergreen Cemetery		20c. Date 6/25/97		20d. Location - City or Town, State Berlin, MD	
	21. Signature of Funeral Service Licensee <i>David A. Thompson</i> M01051				22. Name and Address of Facility Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Complications of Chronic Lymphatic Leukemia</i> Due to (or as a consequence of): b. <i>Leukemia</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Congestive Heart Failure</i> <i>Herpes zoster left trigeminal</i> <i>left hip infection</i>							
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <i>John A. Williams</i> MD				29c. License number D-39813		29d. Date signed (Month, Day, Year) 6/24/97	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>M. Atkins</i> MD 1104 Healthway Dr., Salisbury, MD 21804							
31. Date filed (Month, Day, Year) JUN 26 1997		32. Registrar's Signature <i>John A. Williams</i>						

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.


To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

8+11A

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97 21337

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Roy THOMAS Willey Jr.						2. Date of Death Month June Day 24 Year 1997		3. Time of Death 10:35 PM	
	4a. Facility Name (If not institution, give street and number) Salisbury Center: Genesis ElderCare						4b. City, Town, or Location of Death Salisbury, MD		4c. County of Death Wicomico	
Funeral Director	5. Social Security Number 216-48-6015		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 48 Yrs.		8. Date of Birth (Month, Day, Year) December 26, 1948		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Wicomico		10c. City, Town or Location Salisbury				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 608 Zion Road				10f. Zip Code 21804		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) -				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Auto Body Technician			16b. Kind of Business/Industry Salisbury Auto Body		
	17. Father's Name (First, Middle, Last) Roy thomas Willey Sr.				18. Mother's Name (First, Middle, Maiden Surname) Anna Margaret Harrison					
	19a. Informant's Name/Relationship (Type, Print) Bonnie Jean Willey/wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 1107, Salisbury, MD 21802					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory		20c. Date 6/28/97		20d. Location - City or Town, State Salisbury, MD			
	21. Signature of Funeral Service Licenses 				22. Name and Address of Facility Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death) a. Lung cancer metastatic to brain</p> <p>Due to (or as a consequence of):</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death 5 months</p> </div> </div>									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier 				29c. License number D39813		29d. Date signed (Month, Day, Year) 6/28/97			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WATKINS 1104 Healthway Dr., Salisbury, MD 21804										
State Registrar	31. Date filed (Month, Day, Year) JUN 27 1997		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21338

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ernest Edward Wibben				2. Date of Death Month June Day 18 Year 1997		3. Time of Death 3:35 P.M.	
	4a. Facility Name (If not institution, give street and number) 30344 Calhoun Dr.				4b. City, Town, or Location of Death Salisbury		4c. County of Death Wicomico	
Funeral Director	5. Social Security Number 043-12-4147		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) May 28, 1918	
	9. Birthplace (State or Foreign Country) Connecticut		10a. State MD		10b. County Wicomico		10c. City, Town or Location Salisbury	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 30344 Calhoun Dr.		10f. Zip Code 21804		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Navy If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Automobile Dealership		16b. Kind of Business/Industry Self Employed			
	17. Father's Name (First, Middle, Last) Ernst Wibben				18. Mother's Name (First, Middle, Maiden Surname) Sophie Schreiber			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Barbara M. Wibben - wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30344 Calhoun Dr. Salisbury, MD 21804			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Springhill Memory Gardens		20c. Location - City or Town, State 6-21-97 Hebron, MD		20d. Date	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee B. Keith Phipps CFSP				22. Name and Address of Facility Bounds Funeral Home 705 E. Main St. Salisbury, MD 21804			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac Arrest Due to (or as a consequence of): b. Respiratory Insufficiency Due to (or as a consequence of): c. Interstitial Pulmonary Fibrosis Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death 1 mo 6 mo.
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							29b. Signature and title of certifier Dina J. Houlihan
To Be Completed by Physician/Medical Examiner	29c. License number D04883		29d. Date signed (Month, Day, Year) 06-19-97					
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) HILDA F. HOULIHAN MD 1405 S. Division St, Salisbury							
To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) JUN 19 1997		32. Registrar's Signature Dina J. Houlihan					
	33. Registrar's Title Registrar							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene 97 21339

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George William Wilson				2. Date of Death Month June Day 21 Year 1997		3. Time of Death 8:45 P.M.	
	4a. Facility Name (If not institution, give street and number) 23420 Head Of Creek Road				4b. City, Town, or Location of Death Quantico		4c. County of Death Wicomico	
Funeral Director	5. Social Security Number 220-26-2848		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 10 1932 Maryland	
	9. Birthplace (State or Foreign Country) Maryland							
Usual Residence of Decedent								
10a. State Maryland		10b. County Wicomico		10c. City, Town or Location Quantico			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number P.O. Box 27				10f. Zip Code 21856		10g. Citizen of What Country? U.S.A		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer			16b. Kind of Business/Industry None	
17. Father's Name (First, Middle, Last) William Thomas Wilson				18. Mother's Name (First, Middle, Maiden Surname) Evelyn Perry				
19a. Informant's Name/Relationship (Type, Print) Jacqueline Wilson (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 27 Quantico, Md. 21856				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) St. James Free Meth. Cem. 6/28 Quantico, Md.		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee Bladys B. Stewart				22. Name and Address of Facility Stewart Funeral Home 821 West Rd. Salisbury, Md. 21801				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pancreatic Cancer Due to (or as a consequence of): b. Malnutrition Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 6 mo. 5 mo.
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28d. Describe how injury occurred			28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier James M. D.		29c. License number D19800		
				29d. Date signed (Month, Day, Year) 6/24/97				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 560 Riverside Dr. B200 Salisbury MD 21801								
31. Date filed (Month, Day, Year) JUN 24 1997				32. Registrar's Signature John Davidson Randall				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

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State of Maryland / Department of Health and Mental Hygiene

97 21340

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DOROTHY LORENE WATSON				2. Date of Death Month JUNE Day 18 Year 1997		3. Time of Death 9:50 AM		
	4a. Facility Name (If not institution, give street and number) WICOMICO NURSING HOME				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO		
Funeral Director	5. Social Security Number 218-20-7549		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JAN. 1, 1913	9. Birthplace (State or Foreign Country) MD.	
	Usual Residence of Decedent								
10a. State MD.		10b. County WICOMICO		10c. City, Town or Location HEBRON			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 106 RAILROAD AVENUE				10f. Zip Code 21830		10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SEAMSTRESS		16b. Kind of Business/Industry MANHATTAN SHIRT CO.			
17. Father's Name (First, Middle, Last) UNKNOWN				18. Mother's Name (First, Middle, Maiden Surname) ELIZABETH HUMPHREYS					
19a. Informant's Name/Relationship (Type, Print) WARREN WEBSTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 60 WOLF RIDGE TRAIL, N.E., WHITE, GA. 30184					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) HEBRON CEMETARY		Date 6/20/97		20c. Location - City or Town, State HEBRON, MD.		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility BOUNDS FUNERAL HOME, 705 E. MAIN ST. SALISBURY, MD 21804					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) terminal Pneumonia Due to (or as a consequence of): Aspiration - Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Pen tube Feeding - Due to (or as a consequence of): Diabetes Mellitus - Insulin dependent Diffuse + Severe Atherosclerosis - Decubiti - Gr IV								Approximate Interval Between Onset and Death 5 days months months	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus - Insulin dependent Diffuse + Severe Atherosclerosis - Decubiti - Gr IV						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number d02026		29d. Date signed (Month, Day, Year) June 19-97			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) FEDERICO G. ARTHESE, MD 1622A OCEAN PINES BERLIN, MD 21811									
31. Date filed (Month, Day, Year) JUN 19 1997				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21341

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Henry R. Arenberg

2. Date of Death

Month

Day

Year

3. Time of Death

11:30 AM

4a. Facility Name (If not institution, give street and number)

MANOR CARE

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

219-14-0046

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

OCT. 31, 1924

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2501 MUSGROVE RD.

10f. Zip Code

20784

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give Year or Date WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

BUTCHER

16b. Kind of Business/Industry

FOOD

17. Father's Name (First, Middle, Last)

HERMAN

ARENBERG

18. Mother's Name (First, Middle, Maiden Surname)

IDA

BERKOWITZ

19a. Informant's Name/Relationship (Type, Print)

MRS. BETSEY A. GIBBS (DAUG.)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9507 RED RAIN PATH COLUMBIA, MD 21046

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BETH JACOB ANSHE VESHEAR

Date

7/13/97

20c. Location - City or Town, State

ROSEDALE, MD

21. Signature of Funeral Service Licensee

Jay Alan Lewis

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 REISTERSTOWN RD., PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction
Due to (or as a consequence of):

Approximate interval Between Onset and Death

hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jenny Y. May

29c. License number

D43260

29d. Date signed (Month, Day, Year)

July 11, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jenny Y. May, MD 14333 Laurel Bowie Rd #307 Laurel MD 20708

31. Date filed (Month, Day, Year)

JUL 15 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

21342

ITEM# 5 PER F.H. FLM#G749 7/24/97 J.A.

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

THELMA AUSTIN

2. Date of Death

Month Day Year
JULY 10 1997

3. Time of Death

10:48pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

SINAI HOSPITAL OF BALTIMORE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

213-34-7719

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

63

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
7/23/33

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2520 CYBURN AVENUE

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8 TH GRADE

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOUSE KEEPING

16b. Kind of Business/Industry

In Home

17. Father's Name (First, Middle, Last)

TRAVIS SMITH

18. Mother's Name (First, Middle, Maiden Surname)

EMMA JONES

19a. Informant's Name/Relationship (Type, Print)

ANWAR MUHAMMAD | SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2520 CYBURN AVENUE, BALTO MD 21215

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST

Date

7/15/97 OWINGS MILLS, MD

21. Signature of Funeral Service Licensee

Vaughn C. Greene

22. Name and Address of Facility

VAUGHN C. GREENE FUNERAL SERVICE
5151 BALTO. NATL PIKE, BALTO. MD 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis
Due to (or as a consequence of):b. pneumonia
Due to (or as a consequence of):c. endocarditis
Due to (or as a consequence of):d. renal failure
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jennifer Halpern MD

29c. License number

A52402321-JH9519

29d. Date signed (Month, Day, Year)

JULY 10, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SINAI HOSPITAL OF BALTIMORE 2401 WEST BELVEDERE AVENUE, BALTIMORE, MD 21215

31. Date filed (Month, Day, Year)

JUL 15 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

THOMAS BIGELOW

Item: 20b, per F.H. G-749 7/20/97, rep
ITEM#24a&b PER PHYN. FL#G7 49 7-17-97

State of Maryland / Department of Health and Mental Hygiene

97 21343

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Thomas Bigelow				2. Date of Death Month Day Year JULY 13 1997		3. Time of Death 2:56 PM	
	4a. Facility Name (If not institution, give street and number) 100 HARBORVIEW DRIVE				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death NA	
Funeral Director	5. Social Security Number 194-32-9433	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 54 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 12-14-42		9. Birthplace (State or Foreign Country) PA.
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD.	10b. County NA	10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 100 HarborView Drive Apt. 2107				10f. Zip Code 21230		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) 4year		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Supervisor of Enviromental Ser.			16b. Kind of Business/Industry Univ. of Maryland		
	17. Father's Name (First, Middle, Last) William Bigelow				18. Mother's Name (First, Middle, Maiden Surname) Nancy Cobb			
	19a. Informant's Name/Relationship (Type, Print) Linda A. Bigelow				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21230 100 HarborView Drive Apt. "1207" Balto, Md.			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Allegheny Crematory		Date 07/19/97		20c. Location - City or Town, State Pittsburgh, Pa.	
	21. Signature of Funeral Service Licensee <i>John R. March</i>				22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						24a. Was an autopsy performed? Inspection <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Stephen S. Radentz, MD</i>				29c. License number O.C. M.E.		29d. Date signed (Month, Day, Year) JULY 14, 1997		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Stephen S. Radentz, MD 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) JUL 15 1997				32. Registrar's Signature <i>John Davidson</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: This form requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

97-3826-025

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

CARRIE

State of Maryland / Department of Health and Mental Hygiene

97 21344

BECKER Items: 23a part I, 27 per MEO G-750 8/20/97 dh Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carrie Becker				2. Date of Death Month Day Year JULY 11 1997		3. Time of Death 3:40 P.M.	
	4e. Facility Name (If not institution, give street and number) HARFORD MEMORIAL HOSPITAL				4b. City, Town, or Location of Death HAVRE DE GRACE		4c. County of Death HARFORD COUNTY	
Funeral Director	5. Social Security Number 218-74-8054		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 35 Yrs.		8. Date of Birth (Month, Day, Year) December 7, 1961	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Harford		10c. City, Town or Location Churchville	
Usual Residence of Decedent				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
10e. Street and Number 1105 Glenville Road				10f. Zip Code 21028 - 1103		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Trainer		16b. Kind of Business/Industry Horse Business		
17. Father's Name (First, Middle, Last) Joseph Campanella				18. Mother's Name (First, Middle, Maiden Surname) Nannette Hoover				
19a. Intendant's Name/Relationship (Type, Print) Mr. Randall M. Becker/ Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1105 Glenville Road Churchville, Md. 21028-1103				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. John's Church Cemetery		Date 7/15/97		20c. Location - City or Town, State Hydes, Maryland		
21. Signature of Funeral Service Licensee Mark T. Zavoyna				22. Name and Address of Facility Ruck - Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. RIGHT VENTRICULAR DYSPLASIA OF THE HEART Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? XX Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Walter Bone Juel				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JULY 12, 1997		
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) MARYDAIS A. KOREN RN 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) JUL 15 1997				32. Registrar's Signature John Davidson-Randall				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21345

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Denzil D. Bolyard				2. Date of Death Month Day Year July 14 1997		3. Time of Death 0046	
	4a. Facility Name (If not institution, give street and number) St. Agnes Hospital / 900 CATON Avenue				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 234-54-2269		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 63 Yrs.		8. Date of Birth (Month, Day, Year) May 22, 1934	
					9. Birthplace (State or Foreign Country) West Virginia			
Usual Residence of Decedent								
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Perry Hall				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
10e. Street and Number 4218 Piney Park Road				10f. Zip Code 21128		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th grade College (1-4or 5+) College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machinist		16b. Kind of Business/Industry Manufacturing		
17. Father's Name (First, Middle, Last) Dayton Bolyard				18. Mother's Name (First, Middle, Maiden Surname) Freda Fike				
19a. Informant's Name/Relationship (Type, Print) Lora J. Bolyard (wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4218 Piney Park Rd., Perry Hall, MD 21128				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery		Date 7/16/97		20c. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee [Signature]				22. Name and Address of Facility Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Atherosclerotic coronary vessel disease</u> Due to (or as a consequence of): b. <u>Hypertension</u> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 3 years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier [Signature] Physician		29c. License number 2050907		29d. Date signed (Month, Day, Year) July 14th, 1997		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Craig A. Melville MD 900 South Caton Avenue, Baltimore								
31. Date filed (Month, Day, Year) JUL 15 1997		32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

NAME: DENZIL, BOLYARD

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

JA

State Registrar

DHMM 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21346

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

THEODORE E. BARBOUR

2. Date of Death

Month Day Year
Jul 10 '97 3:22 PM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

BON SECOUR HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

212-20-4711

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
Nov 25, 1923

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

833 W. PRATT ST.

10f. Zip Code

21201

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12TH

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TECHNICIAN

16b. Kind of Business/Industry

WESTINGHOUSE

17. Father's Name (First, Middle, Last)

EDWARD BARBOUR

18. Mother's Name (First, Middle, Maiden Surname)

LILLIAN MERCER

19a. Informant's Name/Relationship (Type, Print)

BEVERLY CARROLL

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

411 CUMBERLAND ST. BALT, MD, 21217

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON-Forest VA 744/97 DUNN'S Mills MD,

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Funeral Home

GARY J. MARCH FUNERAL HOME PA
270 FREDERICK PASS BALT, MD, 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute myocardial infarction

Due to (or as a consequence of):

b. ischemic heart disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

metastatic carcinoma prostate

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

DR. C. KEARNEY MD

29c. License number

D27860

29d. Date signed (Month, Day, Year)

July 11th 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHRISTOPHER D. KEARNEY MD 700 WASH. BLVD BALT MD 21230

31. Date filed (Month, Day, Year)

JUL 15 1997

[Signature]

State Registrar

3 + VR

Theodore Barbour
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed and signed by the attending physician and the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

JA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 21347

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Marguerite Regina Borchers

2. Date of Death

JULY 12 1997

3. Time of Death

7:40 am

4a. Facility Name (If not institution, give street and number)

5 Overbrook Road

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

216-28-5518

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

SEP 18, 1901

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

5 Overlook Road

10f. Zip Code

21228-1945

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Construction Business

17. Father's Name (First, Middle, Last)

George Ernest Straub

18. Mother's Name (First, Middle, Maiden Surname)

Emma Doenges

19a. Informant's Name/Relationship (Type, Print)

LeRoy B. Mathews/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

128 Dunkirk Rd. Baltimore, MD 21212-1750

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Western Cemetery

Date

7/15/97

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Dawn F. McDonald

22. Name and Address of Facility

MacNabb Funeral Home, P.A.
301 Frederick Rd. Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Congestive Heart Failure

Due to (or as a consequence of):

Hypertension

Due to (or as a consequence of):

Aortic Stenosis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Days

Years

Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Senile dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day, Year)

N/A

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Charles R. Davidson

29c. License number

024781

29d. Date signed (Month, Day, Year)

7/19/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

CHARLES R. Davidson 716 UNDER CHURCH LANE S306 BALTIMORE MD

31. Date filed (Month, Day, Year)

JUL 15 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

97 21348

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WILLIAM G. BROWN				2. DATE OF DEATH MONTH 7 DAY 5 YEAR 97		3. TIME OF DEATH 11:20 a.m.	
4. SOCIAL SECURITY NUMBER 705-05-2419		5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) 2-17-15	
9a. FACILITY NAME (If not institution, give street and number) Caton Manor				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH Baltimore City	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore City		10c. CITY, TOWN OR LOCATION Baltimore City		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2434 Christian Street				10f. ZIP CODE 21223		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES unknown		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) unknown		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) unknown		16b. KIND OF BUSINESS/INDUSTRY unknown			
17. FATHER'S NAME (First, Middle, Last) unknown				18. MOTHER'S NAME (First, Middle, Maiden Surname) unknown			
19a. INFORMANT'S NAME (Type/Print) Hanna Brown/wife				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2434 Christian Street, Baltimore, Maryland 21223			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in state		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) in state		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald S. Wade Director				22. NAME AND ADDRESS OF FACILITY State Anatomy Board, 655 W. Baltimore St. Baltimore, Maryland 21201			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Congestive Heart Failure					Approximate interval Between Onset and Death 1 week
		b. Coronary artery					2 years
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER W. H. M. J. Attending Doctor		29c. LICENSE NUMBER D21684		29d. DATE SIGNED (Month, Day, Year) 7-7-97	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) C. V. CYRIAC. M. D. 8109 RITCHIE HWY, Pasadena, MD 21122							
31. DATE FILED (Month, Day, Year) JUL 15 1997		32. REGISTRAR'S SIGNATURE John Davidson					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate is completed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

04515 TC

04515 TC

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21349

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Novella Curtis				2. Date of Death Month July Day 11 Year 97		3. Time of Death 0850	
	4a. Facility Name (If not institution, give street and number) Mercy Hosp. Inc.				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore City	
Funeral Director	5. Social Security Number 219286306		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 61 Yrs.		8. Date of Birth (Month, Day, Year) Dec 9, 35	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 807 BRADHURST ROAD		10f. Zip Code 21212	
	10g. Citizen of What Country? U.S.A.				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry In Home			
	17. Father's Name (First, Middle, Last) Melvin Brunson				18. Mother's Name (First, Middle, Maiden Surname) Mary Holmes			
	19a. Informant's Name/Relationship (Type, Print) Wilson Curtis				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 807 Bradhurst Road, Balto., MD 21212			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) 7/16 Date Carpenters Hill Cemetery		20c. Location - City or Town, State Jones Station, MD	
	21. Signature of Funeral Service Licensee Leroy O. Dyett				22. Name and Address of Facility LEROY O. DYETT & SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE., BALTO. 21207			
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cardiopulmonary collapse, pulmonary edema 3445 Due to (or as a consequence of): Aspiration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dementia 2° to Communicating Hydrocephalus				Approximate Interval Between Onset and Death			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. End stage Metastatic Disease - poorly differentiated Glandular Primary, Dementia 2° to Communicating Hydrocephalus				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) NA		28b. Time of Injury NA		
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				28d. Describe how injury occurred NA				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) NA				28f. Location (Street and Number or Rural Route Number, City or Town, State) Baltimore MD				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier [Signature]				
29c. License number T10020				29d. Date signed (Month, Day, Year) July 11, 1997				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeff M. [Signature] 301 ST. PAUL ST. BALTIMORE, MD				31. Date filed (Month, Day, Year) JUL 15 1997				
32. Registrar's Signature [Signature]								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21350

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANITA CULOTTA				2. Date of Death Month Day Year JULY 11, 1997		3. Time of Death 1:27PM	
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 216-09-1836		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 17, 1920	9. Birthplace (State or Foreign Country) Italy
	Usual Residence of Decedent							
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Lutherville			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 1309 Broadway Road				10f. Zip Code 21093		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th grade College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) Pio Canzani				18. Mother's Name (First, Middle, Maiden Surname) Rose Perruggini				
19a. Informant's Name/Relationship (Type, Print) Vincent A. Culotta (son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1309 Broadway Road, Lutherville, MD 21093				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Most Holy Redeemer Cem.		Date 7/15/97		20c. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)								2-5 YEARS
a. CORONARY ARTERY DISEASE Due to (or as a consequence of):								
b. Due to (or as a consequence of):								
c. Due to (or as a consequence of):								
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
d. Due to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 		29c. License number RES-000		29d. Date signed (Month, Day, Year) JULY 11, 1997				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DR. EMIL HAYEK, M.D. 600 N. WOLFE STREET, BALTIMORE, MARYLAND								
31. Date filed (Month, Day, Year) JUL 15 1997		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 21351

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CELESTE M. CUTINO

2. Date of Death

Month

Day

Year

07

12

97

3. Time of Death

9:30pm

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

215-44-1710

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92

8. Date of Birth

Month Day Year

02-21-1905

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

TOWSON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

11 WEST RD.

10f. Zip Code

21204

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2YRS

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOMEMAKER

17. Father's Name (First, Middle, Last)

ANDREW V. CUTINO

18. Mother's Name (First, Middle, Maiden Surname)

MARY D. SCHAFER

19a. Informant's Name/Relationship (Type, Print)

ROBERT B. COLBERT (P. REP.) 731 CAMBERLEY CIRCLE TOWSON, MD. 21204.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MOST HOLY REDEEMER 07/16/97 BALTO., MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

William L. Jenkins

22. Name and Address of Facility

HENRY W. JENKINS & SONS CO.
4905 YORK RD. BALTO., MD. 21212.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Respiratory Failure

Due to (or as a consequence of)

b. Aspiration

Due to (or as a consequence of)

c. Cerebellar Degeneration

Due to (or as a consequence of)

Approximate Interval Between Onset and Death

Hours

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Alan Shorofsky M.D.

29c. License number

024569

29d. Date signed (Month, Day, Year)

7/15/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALAN SHOROFSKY M.D. 515 FAIRMOUNT AVE. TOWSON, MD. 21204.

31. Date filed (Month, Day, Year)

JUL 15 1997

32. Registrar's Signature

Julia Davidson

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21352

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GLADYS COLBY				2. Date of Death Month Day Year JULY 12, 1997		3. Time of Death 12:40 AM		
	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 214-01-9053		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec 14, 1908		
	9. Birthplace (State or Foreign Country) Maryland								
To Be Completed by Funeral Director	Usual Residence of Decedent								
	10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 2725 Hampden Avenue				10f. Zip Code 21211		10g. Citizen of What Country? U.S.A		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unk College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Fabric Cutter			16b. Kind of Business/Industry Grief Clothing Co			
	17. Father's Name (First, Middle, Last) Ashby Powell				18. Mother's Name (First, Middle, Maiden Surname) Jessie Milton				
	19a. Informant's Name/Relationship (Type, Print) Jack S. Taylor (Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2725 Hampden Avenue, Baltimore, Maryland 21211				
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Cemetery		Date 7/16/97		20c. Location - City or Town, State Baltimore, Maryland		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility A. Alan Seitz, Jr. Funeral Home 3818 Roland Avenue, Baltimore, Maryland 21211				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)								
	SEPSIS								
	Due to (or as a consequence of):								
	ENDOCARDITIS								
	Due to (or as a consequence of):								
	Due to (or as a consequence of):								
	Due to (or as a consequence of):								
	Due to (or as a consequence of):								
	Due to (or as a consequence of):								
	Due to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC ATRIAL FIBRILLATION CHRONIC OBSTRUCTIVE LUNG DISEASE									
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier 				29c. License number D37254		29d. Date signed (Month, Day, Year) 7-12-97			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) BOON P. LIM, M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204									
31. Date filed (Month, Day, Year) JUL 15 1997		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Telling Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial/transit certificate filed with the funeral director.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 21353

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FRANKLIN DONALD COOLEY				2. Date of Death Month Day Year July 10 1997		3. Time of Death 12:02 AM	
	4e. Facility Name (If not institution, give street and number) Suburban Hospital				4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 577-24-5752		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) August 13, 1923	
	9. Birthplace (State or Foreign Country) Missouri		10a. State Virginia		10b. County Fairfax		10c. City, Town or Location Centreville	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 6525 Creek Run Drive		10f. Zip Code 20121	
	10g. Citizen of What Country? USA				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-1945	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3	
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner				16b. Kind of Business/Industry Carpet Retail		17. Father's Name (First, Middle, Last) Franklin Bixby Cooley	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) Ivy Laptad				19. Informant's Name/Relationship (Type, Print) Shirley O. Cooley / Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6525 Creek Run Dr., Centreville, Va. 20121	
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State Alexandria, Va.	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Peter L. Lucitelli				22. Name and Address of Facility MONEY & KING VIENNA FUNERAL HOME, 171 W. Maple Ave., Vienna, Va. 22180			
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac Arrhythmia Due to (or as a consequence of): b. Acute myocardial infarction Due to (or as a consequence of): c. Atherosclerotic coronary artery disease Due to (or as a consequence of): d. { Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Status post recent atherosclerotic aneurysms left internal, right common iliac arteries				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Vicente C. de Guzman MD			
	29c. License number 3025				29d. Date signed (Month, Day, Year) 7-10-97			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) VINCENTE DE GUZMAN 10215 FERNWOOD RD. STE 504 BETHESDA MD 20815				31. Date filed (Month, Day, Year) JUL 15 1997			
	32. Registrar's Signature John D. [Signature]							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21354

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Adeline Cassidy</i>				2. Date of Death Month <i>June</i> Day <i>29</i> Year <i>1997</i>				3. Time of Death <i>5:00 PM</i>								
	4a. Facility Name (If not institution, give street and number) <i>615 Chestnut Ave.</i>				4b. City, Town, or Location of Death <i>Towson</i>				4c. County of Death <i>Baltimore</i>								
Funeral Director	5. Social Security Number <i>218-40-1468</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>91</i> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <i>2/24/06</i>		9. Birthplace (State or Foreign Country) <i>Pennsylvania</i>				
	Usual Residence of Decedent				10a. State <i>Maryland</i>				10b. County <i>Baltimore</i>				10c. City, Town or Location <i>Towson</i>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number <i>615 Chestnut Avenue</i>				10f. Zip Code <i>21204</i>				10g. Citizen of What Country? <i>U.S.A.</i>									
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <i>CAUCASIAN</i>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4or 5+) <i>4</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Substitute Teacher</i>				16b. Kind of Business/Industry <i>School</i>									
17. Father's Name (First, Middle, Last) <i>The Rev. Samuel Barber</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Ellen DeSale</i>													
19a. Informant's Name/Relationship (Type, Print) <i>Martin Cassidy/son</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5 Narrows Court, Silver Spring, Maryland 20906</i>													
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place)				Date		20c. Location - City or Town, State							
21. Signature of Funeral Service Licensee <i>Ronald S. Wade</i>				22. Name and Address of Facility <i>State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201</i>													
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death					
Immediate Cause (Final disease or condition resulting in death) <i>Acute stroke</i>												<i>2 hours</i>					
Due to (or as a consequence of):																	
Due to (or as a consequence of):																	
Due to (or as a consequence of):																	
Due to (or as a consequence of):																	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic obstructive lung disease</i>												23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown					
												24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
												24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)													
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) <i>None</i>		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred							
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>M. Anthony Riley, MD</i>				29c. License number <i>D25205</i>		29d. Date signed (Month, Day, Year) <i>June 30, 1997</i>							
30. Name and address of person who completed cause of death (from 23a) (Type, Print) <i>W.A. Riley GMC 676 N. Charles St. Balto. md 21204</i>																	
31. Date filed (Month, Day, Year) <i>JUL 15 1997</i>																	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been assigned by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

SHIRLEY
DANTZLER

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SHIRLEY DANTZLER

2. Date of Death

Month Day Year
JULY 7 1997

3. Time of Death

3:35 P.M.

4a. Facility Name (If not institution, give street and number)

522 N. CARROLLTON AVE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

219-38-9598

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

60 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 4, 1937

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

522 N. Carrollton Avenue

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Factory Worker

16b. Kind of Business/Industry

Private Business

17. Father's Name (First, Middle, Last)

THOMAS ROBINSON

18. Mother's Name (First, Middle, Maiden Surname)

Hattie Presley

19a. Informant's Name/Relationship (Type, Print)

Sammie Presley / Cousin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2308 N. 5th Street Philadelphia, PA 19133

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

VOSHILL MEMORIAL GARDEN

Date

7-14-97

20c. Location - City or Town, State

Dundalk, Maryland

21. Signature of Funeral Service Licensee

Guy Harris

22. Name and Address of Facility

CHATHAM-HARRIS F.H.
540 REISTERSTOWN ROAD
BALTIMORE, MD 2121523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e. Hypertensive Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?
INSPECTION1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Theodore M. King, M.D.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JULY 8, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Theodore King M.D.

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUL 15 1997

Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21356

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILMA B DAVIS				2. Date of Death Month JULY Day 13 Year 1997		3. Time of Death 12:30 AM		
	4e. Facility Name (If not institution, give street and number) Saint Joseph Medical Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 237-07-5390		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug 17, 1914		
	9. Birthplace (State or Foreign Country) S. Carolina								
To Be Completed by Funeral Director	Usual Residence of Decedent								
	10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 4426 Newport Avenue				10f. Zip Code 21211		10g. Citizen of What Country? U.S.A		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Maker			16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) Leroy Stroud				18. Mother's Name (First, Middle, Maiden Surname) Wilma Davis				
	19a. Informant's Name/Relationship (Type, Print) Mike Davis (Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1113 Jeffra's Court, Westminster, Md 21157				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery		Date 7/16/97		20c. Location - City or Town, State Baltimore, Maryland		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility A. Alan Seitz, Jr. Funeral Home 3818 Roland Avenue, Baltimore, Maryland 21211				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e. PULMONARY EMBOLISM Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								7 DAYS	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No			
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier 				29c. License number D 41410		29d. Date signed (Month, Day, Year) July 13th, 1997			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) JOGINDER P. MEHTA M.D. SAINT JOSEPH MEDICAL CENTER TOWSON, MD.									
31. Date filed (Month, Day, Year) JUL 15 1997				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21357

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

FANNIE MAE DISNEY

2. Date of Death
Month Day Year

JULY 10 1997

3. Time of Death

7:40 PM

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

212-50-4264

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

Sept. 12, 1906

9. Birthplace (State or Foreign
Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

n/a

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

X ☐ Yes 2 ☐ No

10e. Street and Number

2718 Hampden Avenue

10f. Zip Code

21211

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

n/a

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

James E. Wilson

18. Mother's Name (First, Middle, Maiden Surname)

Laura V. Sunderland

19a. Informant's Name/Relationship (Type, Print)

Alan L. Monte-Griffo/Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8 Chamara Court, Cockeysville, MD 21030

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Meadowridge Cemetery

Date

14 July

20c. Location - City or Town, State

1997 Elkridge, MD

21. Signature of Funeral Service Licensee

Victor Lengrand, Jr.

22. Name and Address of Facility

Lemmon Funeral Home of Dulaney Valley, Inc.
10 W. Padonia Rd., Timonium, MD 2109323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

SUBDURAL HEMATOMA

Approximate
Interval Between
Onset and Death

3 DAYS

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ALZHEIMER'S DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending
Investigation
6 ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Joginder P Mehta M.D.

29c. License number

D41410

29d. Date signed (Month, Day, Year)

July 10th, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOGINDER P. MEHTA M.D. 7620 YORK ROAD, TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

JUL 15 1997

32. Registrar's Signature

Johanna Davidson-Rodriguez

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filed with the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21358

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CELIA EISENBERG				2. Date of Death Month JULY Day 8 Year 1997		3. Time of Death 11:30 AM		
	4a. Facility Name (If not institution, give street and number) LEVINDALE				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A		
Funeral Director	5. Social Security Number 215-22-6524		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 96 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JAN. 26, 1901	9. Birthplace (State or Foreign Country) ENGLAND	
	Usual Residence of Decedent								
10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 2500 W. BELVEDERE AVE.				10f. Zip Code 21215		10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER			16b. Kind of Business/Industry OWN HOME		
17. Father's Name (First, Middle, Last) ISAAC				18. Mother's Name (First, Middle, Maiden Surname) TAYLOR REBECCA RUBINSTEIN					
19a. Informant's Name/Relationship (Type, Print) MRS. PHYLLIS STEINBERG (DAUG.)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 124 STRONGWOOD RD. OWINGS MILLS, MD 21117					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MOSES MONTEFIORE WOODMOOR HEBREW		Data 7/10/97		20c. Location - City or Town, State BALTO., MD			
21. Signature of Funeral Service Licensee Ellenore Swinson				22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MYOCARDIAL INFARCTION Due to (or as a consequence of): b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier ATTENDING PHYSICIAN		29c. License number D25610		29d. Date signed (Month, Day, Year) JULY 8, 1997			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEVINDALE 2434 WEST BELVEDERE AVENUE BALTIMORE MD 21215									
31. Date filed (Month, Day, Year) JUL 15 1997									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21359

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARJORIE E. EPPLE

2. Date of Death

Month
JulyDay
13Year
1997

3. Time of Death

0030

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

018-10-4409

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

OCT 17, 1915

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

608 Crocus Drive

10f. Zip Code

20850

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Business Manager

16b. Kind of Business/Industry

Non Profit Organizations

17. Father's Name (First, Middle, Last)

Thomas A. Eddlem

18. Mother's Name (First, Middle, Maiden Surname)

Mary Carton

19a. Informant's Name/Relationship (Type, Print)

Gordon B. Kiefer/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

608 Crocus Dr. Rockville, MD 20850

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metro Crematory, Inc. 7/14/97 Baltimore, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Dawn F. McDonald

22. Name and Address of Facility

Cremation Society of Maryland, Inc.

299 Frederick Rd. Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. MASSIVE ASPIRATION PNEUMONIA

6 HR.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sgt. J. M. McDonald - Attending

29c. License number

023630

29d. Date signed (Month, Day, Year)

July 13, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANK J. MAYO, MD 16220 FREDERICK ROAD #213, GAITHERSBURG, MD 20879

State
Registrar

31. Date filed (Month, Day, Year)

JUL 15 1997

32. Registrar's Signature

Julia Davidson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21360

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joyce May Faulkner				2. Date of Death Month JULY Day 13 Year 1997		3. Time of Death 20:15	
	4e. Facility Name (If not institution, give street and number) ST. AGNES HEALTHCARE				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 219-28-9857		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 20, 1933	
	9. Birthplace (State or Foreign Country) Maryland							
Usual Residence of Decedent								
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Lansdowne			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 245 5th Avenue				10f. Zip Code 21227		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker		16b. Kind of Business/Industry own home		
17. Father's Name (First, Middle, Last) Milton Houck				18. Mother's Name (First, Middle, Maiden Surname) Erma Shilow				
19a. Informant's Name/Relationship (Type, Print) Dawn Sipes, daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 245 5th Avenue Lansdowne, Maryland 21227				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery		Date 7/17		20c. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Road 21227				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last a. ASYSTOLE DUE TO CONGESTIVE HEART FAILURE 30 YEARS Due to (or as a consequence of): b. CHRONIC RENAL FAILURE 20 YEARS Due to (or as a consequence of): c. CHRONIC OBSTRUCTIVE PULMONARY DISEASE 45 YEARS Due to (or as a consequence of): d.								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier  M.D.		29c. License number P10873		29d. Date signed (Month, Day, Year) JULY 13, 1997				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAZEN GHANI, M.D. ST. AGNES HEALTHCARE 900 CATON AVE, BALTIMORE, MD, 21229								
31. Date filed (Month, Day, Year) JUL 15 1997		32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

NAME: FAULKNER, JOYCE MAY

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

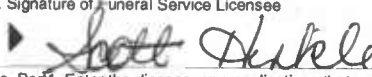
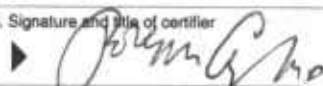

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21361

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Maud E. Feather				2. Date of Death Month 06 Day 17 Year 1997				3. Time of Death 12:24 P.M.													
	4e. Facility Name (If not institution, give street and number) Cuppett Weeks Nursing Home				4b. City, Town, or Location of Death Oakland				4c. County of Death Garrett													
Funeral Director	5. Social Security Number 232-10-3656		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) 11-19-1906		9. Birthplace (State or Foreign Country) Egdon, WV									
	Usual Residence of Decedent																					
To Be Completed by Funeral Director	10a. State Md.		10b. County Garrett		10c. City, Town or Location Oakland				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No													
	10e. Street and Number 706 E. Alder St.				10f. Zip Code 21550				10g. Citizen of What Country? USA													
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White													
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife				16b. Kind of Business/Industry Own Home													
	17. Father's Name (First, Middle, Last) Daniel Grant Judy				18. Mother's Name (First, Middle, Maiden Surname) Rachael Weimer																	
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Arnold G. Feather				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2929 Underwood Rd.																	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Maple Springs				Date 6-21		20c. Location - City or Town, State Egdon, WV											
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Hinkle Funeral Home Box 186, Davis WV 26260																	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																					
	<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) e. Congestive Heart Failure Due to (or as a consequence of): Coronary Artery Disease b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. </td> <td colspan="10"> Approximate Interval Between Onset and Death 2 Months Years </td> </tr> </table>												Immediate Cause (Final disease or condition resulting in death) e. Congestive Heart Failure Due to (or as a consequence of): Coronary Artery Disease b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.	Approximate Interval Between Onset and Death 2 Months Years								
Immediate Cause (Final disease or condition resulting in death) e. Congestive Heart Failure Due to (or as a consequence of): Coronary Artery Disease b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.	Approximate Interval Between Onset and Death 2 Months Years																					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer's Dementia Peripheral Vascular Disease																					
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																					
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																						
State Registrar	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred											
					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)													
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																					
	29b. Signature and title of certifier 				29c. License number D33464				29d. Date signed (Month, Day, Year) June 17, 1997													
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Robert M. Coughlin, M.D., P.O. Box 8, Egdon, WV 26716																						
31. Date filed (Month, Day, Year) JUL 15 1997				32. Registrar's Signature 																		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21362
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARY E. FISHER				2. Date of Death Month July Day 12 Year 1997		3. Time of Death 1426 pm	
	4a. Facility Name (If not institution, give street and number) St. Agnes Hospital				4b. City, Town, or Location of Death Baltimore City		4c. County of Death n/a	
Funeral Director	5. Social Security Number 219-38-7578		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 94 Yrs.		8. Date of Birth (Month, Day, Year) 02-19-03	
	9. Birthplace (State or Foreign Country) RICHMOND, VA		10a. State MD		10b. County n/a		10c. City, Town or Location BALTIMORE	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 2300 ARUNAH AVENUE		10f. Zip Code 21216		10g. Citizen of What Country? UNITED STATES		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4or 5+) Collage		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DOMESTIC		16b. Kind of Business/Industry OUTSIDE of HOME				
17. Father's Name (First, Middle, Last) CLARENCE BROWN				18. Mother's Name (First, Middle, Maiden Surname) SUSAN				
19a. Informant's Name/Relationship (Type, Print) SUSAN MILLS - grand-daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2300 ARUNAH AVENUE, BALTIMORE, MD 21216				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) VOSHELL MEMORIAL		20c. Location - City or Town, State 7-17-97 DUNDALK, MARYLAND				
21. Signature of Funeral Service Licensee Gabrielle Cook		22. Name and Address of Facility WM. C. MARCHFH.-4300 WABASH AVENUE						
23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gastrointestinal Bleeding Due to (or as a consequence of): b. Pulled Gastrostomy Tube Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 1 day 1 day								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. congestion Heart failure Diabetes Mellitus								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier [Signature]		29c. License number D25044		29d. Date signed (Month, Day, Year) July 12, 97				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. R. HANNAH MD, St. Agnes Hosp.								
31. Date filed (Month, Day, Year) JUL 15 1997		32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

NAME: Fisher, Mary

Division of Vital Records, P.O. Box 68760,

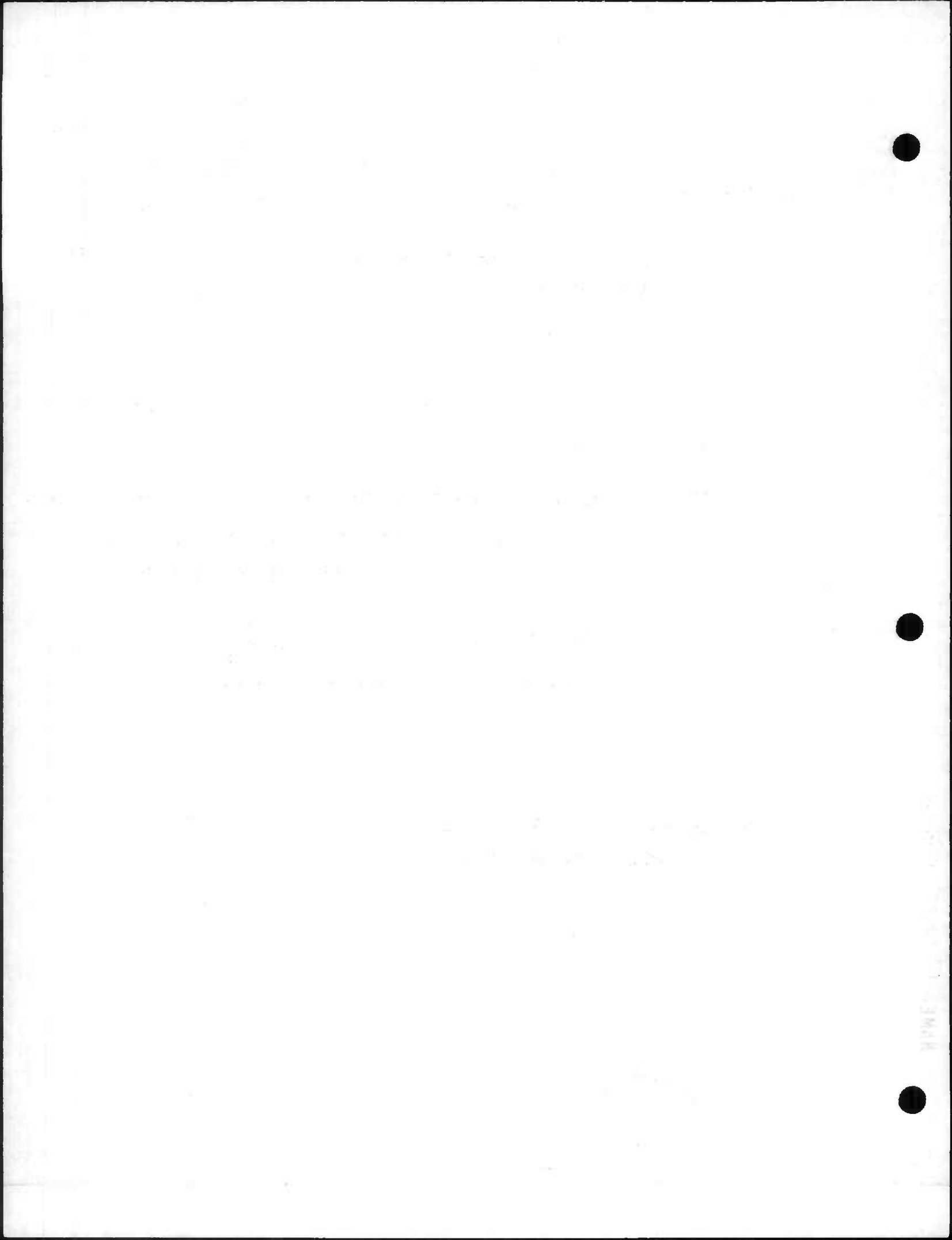
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21363

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HYMAN FREED				2. Date of Death Month Day Year JULY 11, 1997		3. Time of Death 3:16am		
	4a. Facility Name (If not institution, give street and number) STELLA MARIS HOSPICE				4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 217-32-9130		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) MAY 11, 1912		
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MARYLAND		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE		
Usual Residence of Decedent		10d. inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 604 KAHN DRIVE		10f. Zip Code 21208		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) GROCCER		16b. Kind of Business/Industry FOOD		17. Father's Name (First, Middle, Last) DAVID FREED		18. Mother's Name (First, Middle, Maiden Surname) IDA UNKNOWN	
19a. Informant's Name/Relationship (Type, Print) MRS. BETH DENNIS (DAUGHTER)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12115 VELVET HILL DRIVE OWINGS MILLS, MD 21117		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BNAI ISRAEL		20c. Location - City or Town, State 7-13-1997 BALTIMORE, MD	
21. Signature of Funeral Service Licensee		22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208		23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ESCHF Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	
28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Dr. Shirley Thompson		29c. License number 033215		29d. Date signed (Month, Day, Year) 07/11/97		30. Name and address of person who completed cause of death (from 23a) (Type, Print) Dr. Shirley Thompson Richards-7505 Osler Dr-#312-Towson, Md	
31. Date filed (Month, Day, Year) JUL 15 1997		32. Registrar's Signature Julia Davidson-Randall							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21364

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

MARY MAGDALEN FEENEY

2. Date of Death

Month Day Year
07 09 1997

3. Time of Death

2 p.m.

4a. Facility Name (If not institution, give street and number)

713 Maiden Choice Ln Apt 7611

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

5. Social Security Number

212-10-2373

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
NOV 10 1910

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

CATONSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

707 MAIDEN CHOICE LANE 7-G11

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MANAGER

16b. Kind of Business/Industry

MOVING & STORAGE

17. Father's Name (First, Middle, Last)

BONAVENTURE E. von PARIS

18. Mother's Name (First, Middle, Maiden Surname)

TERESA JOSEPHINE ANTON

19a. Informant's Name/Relationship (Type, Print)

ARTHUR G. FEENEY, SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

679 SHORE ROAD, SEVERNA PARK, MD 21146

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SACRED HEART OF JESUS

Date

7-14

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

Philip Hacks

22. Name and Address of Facility

STERLING ASHTON FUNERAL HOME, INC.
736 EDMONDSON AVE. CATONSVILLE, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Atherosclerotic cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial fibrillation

Pulmonary hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mya M Carpenter MD

29c. License number

D 30989

29d. Date signed (Month, Day, Year)

07/10/1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mya M Carpenter MD 711 Maiden Choice Ln Catonsville MD

31. Date (Month, Day, Year)

JUL 15 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21365

Item:26 per ME G-749 7/15/97 dh

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Paul Richard Franck

2. Date of Death

Month July Day 10, Year 1997

3. Time of Death

~ 9 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

10188 Old Frederick Road

4b. City, Town, or Location of Death

Ellicott City

4c. County of Death

Howard

5. Social Security Number

218-42-4837

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

50 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JAN 6, 1947

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10188 Old Frederick Road

10f. Zip Code

21043

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: VIETNAM

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Heavy Equipment Operator

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Walter Franck

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Carolyn Landwehr

19a. Informant's Name/Relationship (Type, Print)

Louis Walter Franck/brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

347 Town Green Way Reisterstown, MD 21136

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc.

Date

7/14/97

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Dawn F. McDonald

22. Name and Address of Facility

MacNabb Funeral Home, P.A.

301 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Asphyxia by Hanging

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

minutes

b. Major Depression

Due to (or as a consequence of):

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

asbestosis.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☒ Other

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☒ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

July 10/97

28b. Time of Injury

~ 9A M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

self-inflicted hanging

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

same as address above.

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dawn F. McDonald ME

29c. License number

D31473

29d. Date signed (Month, Day, Year)

July 11, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

PATRICIA A. TOTE, MD 4565 Hemlock Lane Way Ellicott City MD 21042

31. Date filed (Month, Day, Year)

JUL 15 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital/Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21366

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HENRY PRESTON FALLS				2. Date of Death Month July Day 9 Year 1997		3. Time of Death 1035	
	4a. Facility Name (If not institution, give street and number) St Agnes Healthcare 900 SCATON AVE BALTO.				4b. City, Town, or Location of Death Baltimore City		4c. County of Death Baltimore City	
Funeral Director	5. Social Security Number 223-10-8034		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 26, 1919	
	9. Birthplace (State or Foreign Country) Virginia		10a. State Maryland		10b. County Howard		10c. City, Town or Location Baltimore	
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 5727 Landing Road		10f. Zip Code 21227		
10g. Citizen of What Country? U.S.A.		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1941-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Meat Cutter		16b. Kind of Business/Industry Food		
17. Father's Name (First, Middle, Last) Henry Otis Falls				18. Mother's Name (First, Middle, Maiden Surname) Cora Lee Kaiser				
19a. Informant's Name/Relationship (Type, Print) Josephine P. Falls				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5727 Landing Road, Baltimore, Maryland 21227				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State		20d. Date		
21. Signature of Funeral Service Licensee <i>Ronald S. Wade</i>				22. Name and Address of Facility Ronald S. Wade, Director State Anatomy Board, 655 W. Baltimore St. Baltimore, Maryland 21201				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death)		e. PNEUMONIA Due to (or as a consequence of):				Approximate Interval Between Onset and Death 1 WEEK		
		b. SEPSIS Due to (or as a consequence of):				1 WEEK		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		c. DEHYDRATION Due to (or as a consequence of):				1 WEEK		
		d.						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Mandeep Sandhu MD						
		29c. License number P 10876		29d. Date signed (Month, Day, Year) JULY 09 1997				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 900 CATON AVENUE BALTIMORE, MD 21229		31. Date filed (Month, Day, Year) JUL 15 1997						
32. Registrar's Signature <i>John Anderson</i>								

Certificate of Death

Reg. No.

DMMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21368

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RITA ANNE GRILL				2. Date of Death Month JULY Day 11 Year 1997		3. Time of Death 11:45 PM	
	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 264-14-3351		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) July 26, 1921	
	9. Birthplace (State or Foreign Country) Baltimore, Maryland		10a. State Maryland		10b. County Baltimore City		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10e. Street and Number 3128 Woodholme Avenue		10f. Zip Code 21234		10g. Citizen of What Country? U.S.A.		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary		16b. Kind of Business/Industry Banking			
	17. Father's Name (First, Middle, Last) Joseph DePetrus		18. Mother's Name (First, Middle, Maiden Surname) Lucille Marchioni		19a. Informant's Name/Relationship (Type, Print) Jackie Lewis (Daughter)			
To Be Completed by Physician/Medical Examiner	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 608 Fairway Drive Towson, Maryland 21286		20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Joseph's Church Cemetery July 15, 1997 Baltimore, Maryland		20c. Location - City or Town, State	
	21. Signature of Funeral Service Licensee Deborah Joseph Chipmunk		22. Name and Address of Facility Lassahn Funeral Home, Inc. 7401 Belair Road Baltimore, Maryland 21236-4625		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. CARDIAC TAMPONADE Due to (or as a consequence of): b. DISSECTING ANEURYSM OF ASCENDING AORTA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. Due to (or as a consequence of):			
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier [Signature]		29c. License number D 13140		29d. Date signed (Month, Day, Year) 07-14-97			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REYNALDO ORJUELA-GOMEZ, M.D.		31. Date filed (Month, Day, Year) JUL 15 1997		32. Date of Death (Month, Day, Year) 07-14-97			

Baltimore, Maryland 21215-0020

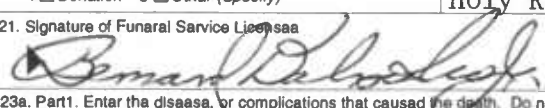
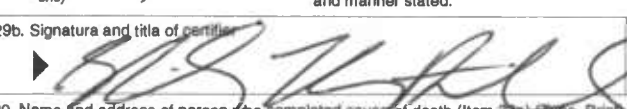
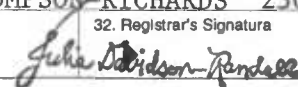
Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21369

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FRANCES GIERCZAK				2. Date of Death Month July Day 14 Year 1997		3. Time of Death 4:25 Am			
	4a. Facility Name (If not institution, give street and number) Stella Maris Nursing Center				4b. City, Town, or Location of Death Timonium		4c. County of Death Baltimore			
Funeral Director	5. Social Security Number 216-07-0620		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 6/6/1915	9. Birthplace (State or Foreign Country) MD		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore City			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 141 N. Kenwood Ave.				10f. Zip Code 21224		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Unk. College (1-4 or 5+) 0			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife			16b. Kind of Business/Industry N/A			
	17. Father's Name (First, Middle, Last) Stanislaus Kocienda				18. Mother's Name (First, Middle, Maiden Surname) Alheco Wykuczka					
	19a. Informant's Name/Relationship (Type, Print) Joyce Dabrowski/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 302 Valdene Ct. Timonium, MD 21093					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Rosary Cemetery		Data 7/17/97		20c. Location - City or Town, State Baltimore Cnty., MD			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility B. Dabrowski & Son Funeral Home 2818 E. Baltimore St. Baltimore, MD 21224					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. COLON CA E LIVER METS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) Hospice								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 								
		29c. License number D33215		29d. Date signed (Month, Day, Year) 07/14/97						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. SHIRLEY THOMPSON-RICHARDS 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093										
31. Date filed (Month, Day, Year) JUL 15 1997		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21370

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EPHRIAM GAINER				2. Date of Death Month JULY Day 08 Year 1997		3. Time of Death 4:55 AM	
	4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL OF BALTIMORE				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death	
Funeral Director	5. Social Security Number 265-07-1415		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 25, 1911	9. Birthplace (State or Foreign Country) Florida
	Usual Residence of Decedent							
10a. State Maryland		10b. County Baltimore City		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10a. Street and Number 4301 Hayward Avenue				10f. Zip Code 21215		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mail Clerk			16b. Kind of Business/Industry Housing Authority	
17. Father's Name (First, Middle, Last) unknown				18. Mother's Name (First, Middle, Maiden Surname) Margaret Gainer				
19a. Informant's Name/Relationship (Type, Print) Barbara Gainer/wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4301 Hayward Avenue, Baltimore, Maryland 21215				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee <i>Ronald S. Wade</i>				22. Name and Address of Facility Ronald S. Wade, Director State Anatomy Facility, 655 W. Baltimore Street Baltimore, Maryland 21201				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE INFERIOR MYOCARDIUM INFARCTION DAY Due to (or as a consequence of): b. CORONARY ARTERY DISEASE YEARS Due to (or as a consequence of): c. S/P VF/VT ARREST DAY Due to (or as a consequence of): d.								Approximate interval between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETE MELLITUS								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
				28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>John V. Wu M.D.</i> HOUSE STAFF PHYSICIAN				
				29c. License number AS2402321JW9022		29d. Date signed (Month, Day, Year) JULY 08, 1997		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN V. WU, M.D. SINAI HOSPITAL OF BALTIMORE, MD 21215								
31. Date filed (Month, Day, Year) JUL 15 1997				32. Registrar's Signature <i>John Davidson-Randall</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 66760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21371

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) ANTHONY HILLARD, SR		2. Date of Death Month Day Year July 09 1997		3. Time of Death 2:10 PM	
4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL		4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death N/A	
5. Social Security Number 323-24-3449		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 66 Yrs.	
8. Date of Birth Month Day Year 7/25/30		9. Birthplace (State or Foreign Country) LOUISIANA			
Usual Residence of Decedent					
10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 1412 W. FRANKLIN STREET		10f. Zip Code 21223		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: BLACK					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 TH GRADE College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LIMOUSINE DRIVER		16b. Kind of Business/Industry KENNEDY KRIEGER	
17. Father's Name (First, Middle, Last) ROOSEVELT HILLARD		18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN			
19a. Informant's Name/Relationship (Type, Print) DEBORAH BROWN DAUGHTER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5826 SPRING HOLLOW DR. TOLEDO, OH 43615			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory, or other place) GARRISON FOREST		20c. Location - City or Town, State 7/13/97 OWINGS MILLS, MD	
21. Signature of Funeral Service Licensee Greg Powell		22. Name and Address of Facility VAUGHN C GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MD 21229			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. Pneumocystis pneumonia Due to (or as a consequence of):		one month	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Retroviral Infection Due to (or as a consequence of):		unknown	
		c.			
		d.			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Greg Powell, MD		29c. License number RES-000		29d. Date signed (Month, Day, Year) July 9, 1997	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greg Powell Johns Hopkins Hospital					
31. Date filed (Month, Day, Year) JUL 15 1997		32. Registrar's Signature John Davidson			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21372

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Cecil U. Hicks Jr.				2. Date of Death Month JULY Day 11, Year 1997		3. Time of Death 2:02 p	
	4a. Facility Name (If not institution, give street and number) 3708 Howard Park				4b. City, Town, or Location of Death Baltimore		4c. County of Death n/a	
Funeral Director	5. Social Security Number 215-30-9972		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 62 Yrs.		8. Date of Birth Month MAY Day 31, Year 1935	
	9. Birthplace (State or Foreign Country) Baltimore		10a. State MD		10b. County n/a		10c. City, Town or Location BALTIMORE	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 3708 HOWARD PARK AVE		10f. Zip Code 21207	
	10g. Citizen of What Country? UNITED STATES				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black				14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 th College (1-4 or 5+) Collegea (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) medical technician				16b. Kind of Business/Industry WALTER REED MEDICAL CENTER		17. Father's Name (First, Middle, Last) CECIL U. HICKS SR.	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) BEULAH				19a. Informant's Name/Relationship (Type, Print) JACQUELINE BELL-		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4958 CLIFTON AVE., BALTIMORE, MD 21207	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) GARRISON FOREST VA		20c. Location - City or Town, State 7-16-97 OWINGS MILLS, MD	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Gabrielle Cook				22. Name and Address of Facility March F/H West F/H 4300 Wabash Avenue Baltimore, Md 21215		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiomyopathy Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alcoholism				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
State Registrar	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) J. DUNLAY MD 1717 GUYTON ORLANDER BALTIMORE MD 21207				31. Date filed (Month, Day, Year) JUL 15 1997		32. Registrar's Signature John Davidson Pendall	

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21373

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MELVIN FRANCIS HOLLAND				2. Date of Death Month Day Year July 12, 1997		3. Time of Death 4:10 PM	
	4e. Facility Name (If not institution, give street and number) 3907 Hannon Ct. Unit 1A				4b. City, Town, or Location of Death Perry Hall		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 218-01-0373		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) Apr. 11, 1920	
	9. Birthplace (State or Foreign Country) Md.		10a. State Md.		10b. County Baltimore		10c. City, Town or Location Perry Hall	
Usual Residence of Decedent								
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
10e. Street and Number 3907 Hannon Ct. Unit 1A								
10f. Zip Code 21236								
10g. Citizen of What Country? USA								
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW-II			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: White			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) College			16. Kind of Business/Industry Church Hill Distributors		
17. Father's Name (First, Middle, Last) Melvin F. Holland			18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Kershaw			19. Informant's Name/Relationship (Type, Print) Mrs. Emma Holland/wife		
19a. Informant's Name/Relationship (Type, Print) Mrs. Emma Holland/wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3907 Hannon Ct. Unit 1A Perry Hall, Md. 21236			20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp.			20c. Location - City or Town, State Towson, Md.			21. Signature of Funeral Service Licensee 		
22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204			23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Circ / Lung Metastases Due to (or as a consequence of): b. Cancer of Colon Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 2 Mo 3 yr			23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Some Metastases		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		
28a. Date of Injury (Month, Day Year)			28b. Time of Injury M			28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier 			29c. License number D10091		
29d. Date signed (Month, Day, Year) 7/14/97			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arthur A. Scarpella MD St Joseph Med Ctr Towson, Md			31. Date filed (Month, Day, Year) JUL 15 1997		
32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21374

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Mary Hess</u>				2. Date of Death Month <u>July</u> Day <u>12</u> Year <u>1997</u>				3. Time of Death <u>9:30 AM</u>			
	4a. Facility Name (If not institution, give street and number) <u>GILCHRIST CENTER 6601 N. CHARLES ST. BALT.</u>				4b. City, Town, or Location of Death <u>BALTIMORE</u>				4c. County of Death <u>BALTIMORE</u>			
Funeral Director	5. Social Security Number <u>212-16-5408</u>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>80</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>MAY 13, 1917</u>		9. Birthplace (State or Foreign Country) <u>New York</u>			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State <u>Maryland</u>		10b. County <u>N/A</u>		10c. City, Town or Location <u>Baltimore</u>				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number <u>111 Hamlet Hill Road</u>				10f. Zip Code <u>21210</u>		10g. Citizen of What Country? <u>USA</u>					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>White</u>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u></u>			18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Teacher</u>			16b. Kind of Business/Industry <u>Tap Dance</u>					
	17. Father's Name (First, Middle, Last) <u>William Martin Brown</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Lena G. Veeder</u>							
	19a. Informant's Name/Relationship (Type, Print) <u>Carol Hess-Vait/daughter</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>225 N. Beaumont Avenue Catonsville, MD 21228</u>							
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Metro Crematory, Inc.</u>		Date <u>7/14/97</u>		20c. Location - City or Town, State <u>Baltimore, MD</u>					
	21. Signature of Funeral Service Licensee <u>Dawn F. McDonald</u>				22. Name and Address of Facility <u>Cremation Society of Maryland, Inc.</u> <u>299 Frederick Road Baltimore, MD 21228</u>							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <u>metastatic Breast Cancer</u>										Approximate Interval Between Onset and Death <u>2 months</u>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>rectal cancer</u>										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <u>Hospice</u>									
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <u>None</u>		28b. Time of Injury <u>M</u>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
	29b. Signature and title of certifier <u>W.A. Riley, MD</u>				29c. License number <u>D25205</u>		29d. Date signed (Month, Day, Year) <u>July 12, 1997</u>					
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>W.A. Riley MD, GBAK 6701 N. Charles St. Balto, MD 21204</u>											
	31. Date (Month, Day, Year) <u>JUL 15 1997</u>											

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21375

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Pansy Helen Hyry

2. Date of Death

Month Day Year
JULY 10, 1997

3. Time of Death

11:30 AM

4a. Facility Name (If not institution, give street and number)

123 Academy Street

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

474-03-0255

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
NOV 28, 1915

9. Birthplace (State or Foreign Country)

Minnesota

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

123 Academy Street

10f. Zip Code

21401

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Factory Worker

16b. Kind of Business/Industry

Paint Company

17. Father's Name (First, Middle, Last)

John Ephram Wiinamaki

18. Mother's Name (First, Middle, Maiden Surname)

Anna Sophia Simo

19a. Informant's Name/Relationship (Type, Print)

Suzanne B. Buttinger/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

123 Academy St. Annapolis, MD 21401

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc. 7/11/97

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Dawn F. McDonald

22. Name and Address of Facility

Cremation Society of Maryland, Inc.
299 Frederick Rd. Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Metastatic breast cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D44465

29d. Date signed (Month, Day, Year)

07/10/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ann C. Mosley, M.D., 900 Beut gate Road, Annapolis, MD 21401

31. Date filed (Month, Day, Year)

JUL 15 1997

Registrar's Signature

J. Davidson

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21376

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Mary</i>				2. Date of Death Month <i>Jul</i> Day <i>6</i> Year <i>1997</i>				3. Time of Death <i>600 PM</i>	
	4a. Facility Name (If not institution, give street and number) <i>Corien Nursing Home</i>				4b. City, Town, or Location of Death <i>Columbia</i>				4c. County of Death <i>Howard</i>	
Funeral Director	5. Social Security Number <i>204-12-0615</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>70</i> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) <i>Dec. 17, 1926</i>		9. Birthplace (State or Foreign Country) <i>Pennsylvania</i>		Usual Residence of Decedent					
To Be Completed by Funeral Director	10a. State <i>Maryland</i>		10b. County <i>Baltimore</i>		10c. City, Town or Location <i>Catonsville</i>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <i>2207 Rockwell Avenue</i>				10f. Zip Code <i>21228</i>		10g. Citizen of What Country? <i>U.S.A.</i>			
	11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>0</i>			16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Systems Analyst</i>			16b. Kind of Business/Industry <i>Computer</i>			
	17. Father's Name (First, Middle, Last) <i>Edward Rutledge</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Jessie O'Connell</i>					
	19. Informant's Name/Relationship (Type, Print) <i>Priscilla J. Atwater/daughter</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>134 Sanford Avenue, Baltimore, Maryland 21228</i>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <i>in state</i>		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State			
	21. Signature of Funeral Service Licensee <i>Ronald S. Wade</i> Director				22. Name and Address of Facility <i>State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201</i>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. Emphysema</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>b. Due to (or as a consequence of):</i> <i>c. Due to (or as a consequence of):</i> <i>d. Due to (or as a consequence of):</i>								Approximate Interval Between Onset and Death <i>20 years</i>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Respiratory failure</i>								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Doug Kay MD</i>		29c. License number <i>D41617</i>		29d. Date signed (Month, Day, Year) <i>Jul 6, 1997</i>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Gary Kozlov 10805 Hickory Ridge Rd Columbia, MD 21047</i>										
31. Date filed (Month, Day, Year) <i>Jul 15 1997</i>		32. Registrar's Signature <i>Julia Baylson-Randall</i>								

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 66760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

25.11.19

Dear Sir,
I have the pleasure to acknowledge the receipt of your letter of the 11th inst. in relation to the above matter.
The same has been forwarded to the appropriate authorities for their consideration.
I am, Sir, very respectfully,
Yours faithfully,
[Signature]

Very truly yours,
[Signature]
[Name]
[Title]
[Address]
[City]
[Country]

97-3817-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

VALENTINE

State of Maryland / Department of Health and Mental Hygiene

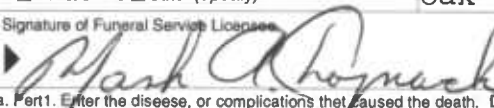
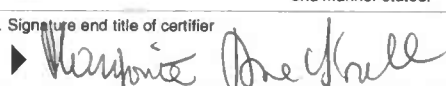
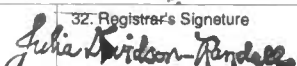
97 21377

HAWRYLENKO Items:23a part I,27,28a-f per MEO

G-749 7/23/97 dh

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Valentin Hawrylenko				2. Date of Death Month JULY Day 11 Year 1997		3. Time of Death 9:04A.M.	
	4e. Facility Name (If not institution, give street and number) JOHNS HOPKINS BAYVIEW MEDICAL CENTER				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death NA	
Funeral Director	5. Social Security Number 217-52-53333		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 47 Yrs.		8. Date of Birth (Month, Day, Year) March 12 50	
	9. Birthplace (State or Foreign Country) Germany		10a. State Maryland		10b. County NA		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 1235 Broening Highway		10f. Zip Code 21224		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) NA		18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machinst		16b. Kind of Business/Industry Yeast Factory			
	17. Father's Name (First, Middle, Last) George Hawrylenko		18. Mother's Name (First, Middle, Maiden Surname) Maria Kozachok		19a. Informant's Name/Relationship (Type, Print) Maria Hawrylenko (Mother)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1235 Broening Highway Balto., Md. 21224	
Physician /Medical Examiner	20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn		Date July 14		20c. Location - City or Town, State East Point, Maryland	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility W. Dabrowski/Chojnacki F.H. P.A. 1005 Dundalk Ave. Baltimore, Md. 21224		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e. NARCOTIC INTOXICATION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death	
Division of Vital Records, P.O. Box 68760,	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
					24e. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) found:7/11/97	
	28b. Time of Injury found:8:20^M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred unknown		28f. Location (Street and Number or Rural Route Number, City or Town, State) 1235 Broening Highway, Baltimore, Maryland	
Medical Certification: To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JULY 12, 1997	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MARYLENE A. KORELL MD 111 Penn Street, Baltimore, Maryland 21201		31. Date filed (Month, Day, Year) JUL 15 1997		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21378

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Mazie D. Johnson

2. Date of Death

Month Day Year
July 9, 1997

3. Time of Death

11:40 PM

4a. Facility Name (If not institution, give street and number)

9501 Belair Road

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

217-05-9499

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 9, 1905

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9501 Belair Road

10f. Zip Code

21236

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

9th grade

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Clothing Manufacturer

17. Father's Name (First, Middle, Last)

Frank

King

18. Mother's Name (First, Middle, Maiden Surname)

Annie

Dean

19a. Informant's Name/Relationship (Type, Print)

Lorraine Johnson (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9501 Belair Road, Baltimore, MD 21236

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery

Date

7/12/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Homes, Inc.
9705 Belair Road, Baltimore, MD 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Dementia, Alzheimer's type

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

OSTEOPOROSIS, SEVERE

DECUBITUS ULCER

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D20390

29d. Date signed (Month, Day, Year)

7/10/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Charles Hoesch, 9712 Belair Rd, Baltimore, MD 21236

31. Date filed (Month, Day, Year)

JUL 15 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

4

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21379

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM THOMAS KELLEY Jr				2. Date of Death Month JULY Day 10 Year 1997		3. Time of Death 9:30 AM	
	4a. Facility Name (If not institution, give street and number) 8150 POTOBAC LANDING ROAD				4b. City, Town, or Location of Death PORT TOBACCO		4c. County of Death CHARLES	
Funeral Director	5. Social Security Number 213-03-5776		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) 12/2/16	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MARYLAND		10b. County CHARLES		10c. City, Town or Location PORT TABACCO	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number P.O. Box 272		10f. Zip Code 20677		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th GRADE College (1-4 or 5+) COLLEGE		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) STEEL WORKER		16b. Kind of Business/Industry BETHLEHEM STEEL			
	17. Father's Name (First, Middle, Last) WILLIAM T. KELLEY, SR.				18. Mother's Name (First, Middle, Maiden Surname) FLORENCE MAY BARTON			
	19a. Informant's Name/Relationship (Type, Print) DOROTHY KELLEY WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 272 PORT TABACCO, MD 20677			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Moreland Memorial Park		20c. Date 7/14/97		20d. Location - City or Town, State HILLENDALE, MD	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 21286			
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CANCER OF PROSTATE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number 022352		29d. Date signed (Month, Day, Year) 7-10-97		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P O Box 1703 LaPlata Md 20646								
31. Date filed (Month, Day, Year) JUL 15 1997				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

97 21380

FOR
STATE
REGISTRAR Item: 7per F.H G-749 7/15/97

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Richard V. King Sr.</u>				2. DATE OF DEATH MONTH <u>07</u> DAY <u>12</u> YEAR <u>97</u>		3. TIME OF DEATH <u>11:00 A.M.</u>	
4. SOCIAL SECURITY NUMBER <u>421-07-7179</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>80</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>11/21/16</u>	
8. BIRTHPLACE (State or Foreign Country) <u>Mobile Alabama</u>				9a. FACILITY NAME (If not institution, give street and number) <u>Caton Manor Nursing Home</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u>	
9c. COUNTY OF DEATH <u>Baltimore City</u>				10a. STATE <u>md</u>		10b. COUNTY <u>Baltimore City</u>	
10c. CITY, TOWN OR LOCATION <u>Baltimore</u>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <u>3314 Monday Ave</u>	
10f. ZIP CODE <u>21216</u>				10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>Black</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12 Grade</u> College (1-4 or 5+) <u></u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Able Body Seaman</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Merchant Seaman</u>	
17. FATHER'S NAME (First, Middle, Last) <u>Richard King</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Alice Bodan</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Maryetta King/wife</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3314 Monday Ave. Baltimore, MD 21216</u>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Metro Crematory, Inc. 7/14/97</u>		20c. LOCATION — City or Town, State <u>Baltimore, MD</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Dawn F. McDonald</u>				22. NAME AND ADDRESS OF FACILITY <u>Cremation Society of Md., Inc. 299 Frederick Rd. Baltimore, MD 21228</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Carcinoma of the Colon</u> DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death: <u>3 Months</u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST: b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>William M. Attending Doctor</u>				29c. LICENSE NUMBER <u>D 21684</u>		29d. DATE SIGNED (Month, Day, Year) <u>7-13-97</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>C.V. CYRIAC - M.D. 8109 Ralston Gwy, Pasadena, MD 21222</u>							
31. DATE FILED (Month, Day, Year) <u>JUL 15 1997</u>				32. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21381

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SARRA				2. Date of Death Month JULY Day 13 Year 1997				3. Time of Death 1:45AM	
	4a. Facility Name (If not institution, give street and number) LORIE NURSING HOME				4b. City, Town, or Location of Death COLUMBIA				4c. County of Death HOWARD	
Funeral Director	5. Social Security Number 219-45-4441		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 91 Yrs.		8. Date of Birth (Month, Day, Year) JAN. 12 1906		9. Birthplace (State or Foreign Country) RUSSIA	
	Usual Residence of Decedent									
10a. State md		10b. County HOWARD		10c. City, Town or Location COLUMBIA				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 7080 CRADLEROCK WAY APT. 206				10f. Zip Code 21045		10g. Citizen of What Country? RUSSIA				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) NONE College (1-4 or 5+) HOMEMAKER				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) OWN HOME			16b. Kind of Business/Industry			
17. Father's Name (First, Middle, Last) MOTL				18. Mother's Name (First, Middle, Maiden Surname) YENTA UNKNOWN						
19a. Informant's Name/Relationship (Type, Print) MUNYA LEZNIK (SON)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7080 CRADLEROCK WAY #320 COLUMBIA, MD 21045						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) ARLINGTON (CHIZUK AMUNO)			20c. Location - City or Town, State 7/14/97 BALTIMORE, MD				
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gangrene (R) leg Due to (or as a consequence of): b. Peripheral vascular disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Insulin dependent diabetes mellitus										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
				28d. Describe how injury occurred			28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Pio L. Poblete MD</i>			29c. License number D50338		29d. Date signed (Month, Day, Year) July 13, 1997	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11055 Little Patuxent Parkway, Columbia MD, 21044 Pio L. Poblete M.D.										
31. Date filed (Month, Day, Year) JUL 15 1997										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed, it must be filed in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

MICHAEL
LEBRUN

State of Maryland / Department of Health and Mental Hygiene

97 21382

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Michael E. LeBrun						2. Date of Death Month Day Year JULY 13 1997		3. Time of Death 2:05 P.M.	
	4a. Facility Name (If not institution, give street and number) 27 NEWBURG AVE						4b. City, Town, or Location of Death CATONSVILLE		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 217-98-7454		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 30 Yrs.		8. Date of Birth (Month, Day, Year) Feb 4, 1967		9. Birthplace (State or Foreign Country) Md	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Md		10b. County Howard		10c. City, Town or Location Columbia				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 10850 Green Mountain Circle #217				10f. Zip Code 21044		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Helper			16b. Kind of Business/Industry Liquor Distributor		
	17. Father's Name (First, Middle, Last) Unknown						18. Mother's Name (First, Middle, Maiden Surname) Emily Ruth Adams			
	19a. Informant's Name/Relationship (Type, Print) Emily Ruth Adams/Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10850 Green Mountain Circle #217 Columbia, Md 21044					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Lorraine Park		Date 7/17		20c. Location - City or Town, State Baltimore, Md.	
	21. Signature of Funeral Service Licensee <i>Peter S. Osheski</i>				22. Name and Address of Facility Sterling Ashton Funeral Home, Inc 736 Edmondson Avenue, Balto, Md. 21228					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Hanging Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No									
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined										
28a. Date of Injury (Month, Day, Year) 7-13-97										
28b. Time of Injury Found 4:20 AM										
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
28d. Describe how injury occurred Subject hanged himself										
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Home										
28f. Location (Street and Number or Rural Route Number, City or Town, State) 27 Newburg Avenue Baltimore County, Maryland										
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <i>Stephen S. Radentz, MD</i>										
29c. License number O.C.M.E.										
29d. Date signed (Month, Day, Year) JULY 14, 1997										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz, MD 111 Penn Street, Baltimore, Maryland 21201										
31. Date filed (Month, Day, Year) JUL 15 1997										
32. Registrar's Signature <i>Julia Anderson-Randall</i>										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21383

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOSEPH PATRICK LANE

2. Date of Death

Month Day Year
JULY 12, 1997

3. Time of Death

4:34 AM

4a. Facility Name (If not institution, give street and number)

HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

213-09-2582

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

AUG 24 1913

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

DUNDALK

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2442 KEYWAY

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SHIPBUILDER

16b. Kind of Business/Industry

Beth. Steel

17. Father's Name (First, Middle, Last)

BARTHOLOMEW A. LANE

18. Mother's Name (First, Middle, Maiden Surname)

WANEITA M. CUNNINGHAM

19a. Informant's Name/Relationship (Type, Print)

BARBARA SARLIN, DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

413 GOLF COURSE DRIVE, ARNOLD, MD 21012

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHESAPEAKE CREMATORY

Date

7-13

20c. Location - City or Town, State

BELTSVILLE, MD

21. Signature of Funeral Service Licensee

Bally

22. Name and Address of Facility

BRADLEY-ASHTON FUNERAL HOME, INC.

2134 WILLOW SPRING RD., BALT., MD 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. ADENOCARCINOMA RIGHT COLON

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

f. NON INSULIN DEPENDENT DIABETES MELLITUS

Due to (or as a consequence of):

1 yr +

g. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

1 yr +

h. PERITONITIS, ANASTOMOTIC LEAK

9 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MALNUTRIETION, HYPOPROTEINEMIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

B. Aquilino M.D.

29c. License number

D28988

29d. Date signed (Month, Day, Year)

JULY 12, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

LINDA R. ARQUILLANO MD 3001 SOUTH HANOVER ST BALT. MD

31. Date filed (Month, Day, Year)

JUL 15 1997

32. Registrar's Signature

J. J. J.

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21384

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SHELDON

2. Date of Death

Month Day Year

JULY 1, 1997

3. Time of Death

500pm

4a. Facility Name (If not institution, give street and number)

MARYLAND GENERAL HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

Funeral
Director

5. Social Security Number

215-30-5280

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

63

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 10, 1934

9. Birthplace (State or Foreign Country)

unknown

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore City

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

501 West Franklin Street

10f. Zip Code

21201

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☐ No
If Yes, Give Year or Dates: unknown

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)
unknown unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

unknown

16b. Kind of Business/Industry

unknown

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

Thelma Freedman/aunt

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3148 Church Lane Blvd B1, Chesapeake, Virginia 23321

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☒ Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade Director

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore Street
Baltimore, Maryland 21201

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

b. PNEUMONIA.

Due to (or as a consequence of):

c. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Faye Johnson M.D.

29c. License number

89295

29d. Date signed (Month, Day, Year)

7/1/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Parag Dalsania, M.D. 40 Maryland General Hospital

31. Date filed (Month, Day, Year)

JUL 15 1997

32. Registrar's Signature

J. H. Johnson

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21385

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Grace Concetta Leisher				2. Date of Death Month Day Year July 13 1997		3. Time of Death 1:00 a.m.	
	4a. Facility Name (If not institution, give street and number) 7936 Bank Street				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 214-14-9626	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 12, 1922		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 7936 Bank Street				10f. Zip Code 21224		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 6				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seamstress			16b. Kind of Business/Industry Clothing Manufacturing	
17. Father's Name (First, Middle, Last) Frank Garbo				18. Mother's Name (First, Middle, Maiden Surname) Anglina Lamartina				
19a. Informant's Name/Relationship (Type, Print) William Leisher / Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3610 Southside Avenue, Phoenix, MD 21131				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral Cemetery		20c. Location - City or Town, State 7/16/97 Baltimore, Maryland		
21. Signature of Funeral Service Licensee <i>Gaine J. Phillips</i>				22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Avenue, Baltimore, MD 21229				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Congestive heart failure</i> Due to (or as a consequence of): b. <i>atrial fibrillation</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. <i>Diabetes</i> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 2 wks 3 months
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
				28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>Michael D. Martin MD</i>		29c. License number D41968		29d. Date signed (Month, Day, Year) 7/14/97
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael D. Martin MD 1576 Merritt Blvd. Dundalk, MD. 21222								
31. Date filed (Month, Day, Year) JUL 15 1997								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21386

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Susie Mae Norton-Dubose</i>		2. Date of Death Month <i>July</i> Day <i>14</i> Year <i>1997</i>		3. Time of Death <i>4:28 PM</i>
	4e. Facility Name (If not institution, give street and number) STELLA-MARIS-HOSPICE at MERCY		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death n/a
Funeral Director	5. Social Security Number 213-26-4157	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) JAN. 20, 1928		9. Birthplace (State or Foreign Country) NEW YORK		
Usual Residence of Decedent					
10a. State MD		10b. County n/a		10c. City, Town or Location BALTIMORE	
10e. Street and Number 4000 GRANTLEY ROAD		10f. Zip Code 21215		10g. Citizen of What Country? UNITED STATES	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) - College (1-4 or 5+) 1 year			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NURSE- HOME HEALTH CARE		16b. Kind of Business/Industry STATE of MARYLAND			
17. Father's Name (First, Middle, Last) WILLIAM COOK			18. Mother's Name (First, Middle, Maiden Surname) MARIE AGEE		
19a. Informant's Name/Relationship (Type, Print) CORNELL S. MORTON-SON			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4000 GRANTLEY ROAD, BALTIMORE, MD 21215		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) WOODLAWN CEMETERY		20c. Location - City or Town, State 7-17-97 BALTIMORE co., MD	
21. Signature of Funeral Service Licensee <i>Gabrielle Cook</i>		22. Name and Address of Facility WM. C. MARCH FH.-4300 WABASH AVENUE			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>BRAIN metastasis</i> Due to (or as a consequence of): b. <i>Lung Cancer</i> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Approximate Interval Between Onset and Death <i>5 months</i> <i>13 months</i>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <i>Stella Maris of Mercy Hospice</i>					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>Dr. Fernando J. Ferraz MD</i>		29c. License number 040480		29d. Date signed (Month, Day, Year) July, 14, 1997	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FERNANDO J. FERRAZ MD 5810 BELAIR RD BALTO, MD 21206					
31. Date filed (Month, Day, Year) JUL 15 1997		32. Registrar's Signature <i>John Davidson-Randall</i>			

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21387

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Almie McIntyre, Sr.				2. Date of Death Month July Day 09 Year 1997		3. Time of Death 6:15 PM	
	4e. Facility Name (If not institution, give street and number) Multi-Medical Center 7700 York Rd				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 218-10-8205		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 98 Yrs.		8. Date of Birth (Month, Day, Year) 10/14/1898	
	9. Birthplace (State or Foreign Country) S. Carolina		10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE	
To Be Completed by Funeral Director	10e. Street and Number 4305 ADELL TERRACE #204				10f. Zip Code 21229		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+)				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Emergency Room Assistant		16b. Kind of Business/Industry Hospital	
	17. Father's Name (First, Middle, Last) Walter Bishop				18. Mother's Name (First, Middle, Maiden Surname) Ammie McIntyre			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Almie McIntyre, Jr.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21228 34 Kimball Ridge Court, Catonsville, MD			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery		Date 7/15		20c. Location - City or Town, State Baltimore, Maryland	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Leroy O. Dyett				22. Name and Address of Facility LEROY O. DYETT & SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE., BALTO. 21207			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Silent MI or Asystole Due to (or as a consequence of): b. AHD Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Peripheral Vascular Disease G.E. R.D.				Approximate Interval Between Onset and Death Minutes years			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Peripheral Vascular Disease G.E. R.D.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28e. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how Injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier Medical Attending		29c. License number D17118		29d. Date signed (Month, Day, Year) 7/11/97			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Paul Schwartz M.D. 4000 Old Court Rd #203 21208							
To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) JUL 15 1997		32. Registrar's Signature Johnardson-Rendell					
	State Registrar							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21388

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HELENE MOSES				2. Date of Death Month Day Year JULY 9, 1997		3. Time of Death 3:20am	
	4a. Facility Name (If not institution, give street and number) 1 SLADE AVE, APT. 406				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 219-40-4165		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 93 Yrs.		8. Date of Birth (Month, Day, Year) SEPT. 7, 1903	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MARYLAND		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 1 SLADE AVE., APT. 406		10f. Zip Code 21208		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry OWN HOME			
	17. Father's Name (First, Middle, Last) HENRY LOBE				18. Mother's Name (First, Middle, Maiden Surname) AMELIA BACHRACH			
	19a. Informant's Name/Relationship (Type, Print) ALFRED MOSES (SON)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1201 PENNSYLVANIA AVE. WASHINGTON, DC 20044			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE HEBREW		Date 7/13/97		20c. Location - City or Town, State BALTIMORE, MD	
	21. Signature of Funeral Service Licensee <i>Scott M. Guttler</i>				22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 Reisterstown Road Pikesville, MD 21208			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Respiratory Failure Due to (or as a consequence of): b. Bacterial Pneumonia - Bilobar Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. OBSTRUCTIVE, HYPERTROPHIC CARDIOMYOPATHY KYPHOSCOLIOSIS							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Laura M. Mumford MD</i>		29c. License number D18410		29d. Date signed (Month, Day, Year) 7/9/97		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Laura M. Mumford, MD 10755 Falls Road, #470, Lutherville, MD 21093								
31. Date filed (Month, Day, Year) JUL 15 1997		32. Registrar's Signature <i>Julia Davidson-Randall</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 21389

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARIE T. MARLOWE				2. Date of Death Month Day Year July 12, 1997		3. Time of Death 9:40 AM	
	4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 214-03-4501	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 13, 1920		9. Birthplace (State or Foreign Country) Md.
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Md.	10b. County Baltimore	10c. City, Town or Location Towson			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 112 Beech View Ct.				10f. Zip Code 21286		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Maker			16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) William Dauber				18. Mother's Name (First, Middle, Maiden Surname) Mary Seufert			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mr. Albert T. Marlowe, Jr./spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 112 Beech View Ct. Towson, Md. 21286			
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) Entombment		20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Memorial		Date 7/15/97		20c. Location - City or Town, State Timonium, Md.	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Presumed myocardial infarction Due to (or as a consequence of): b. Hyperlipidemia Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Approximate Interval Between Onset and Death minutes							
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal failure, hypertension, obstructive airway disease						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Subacute					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 7-12-97		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28a. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier Howard Steiner MD				29c. License number D38403		29d. Date signed (Month, Day, Year) 7-12-97	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. Steiner 5601 Loch Raven Blvd, Balto 21239							
31. Date filed (Month, Day, Year) JUL 15 1997								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

6

97-3825-510

CHARLES
MURRAY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 21390

Reg. No.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Charles Edward Murray		2. Date of Death Month JULY Day 11 Year 1997		3. Time of Death 7:30 P.M.	
4a. Facility Name (If not institution, give street and number) 3512 LUCILLE AVE			4b. City, Town, or Location of Death BALTIMORE		4c. County of Death none
5. Social Security Number 212-34-6563	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 60 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) February 13, 1937
9. Birthplace (State or Foreign Country) Maryland					
10a. State Maryland		10b. County none		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 3512 Lucille Ave			10f. Zip Code		10g. Citizen of What Country? USA
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1955		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Postal Worker		14. Race - American Indian, Black, White, etc. Afro American	
17. Father's Name (First, Middle, Last) Charles Murray		18. Mother's Name (First, Middle, Maiden Surname) Dorothy E. White			
19a. Informant's Name/Relationship (Type, Print) Carolyn Rice		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5915 Morningbird Lane Columbia, Md. 21045			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) meteo		20c. Location - City or Town, State 7/15/97 Catonsville, Md	
21. Signature of Funeral Service Licensee James M. Leland		22. Name and Address of Facility Wallace Funeral Service 3405 W. Franklin St. Baltimore, Md 21229			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Arteriosclerotic Cardiovascular Disease					
Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? INSPECTION <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier James M. Leland		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JULY 12, 1997	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) JUL 15 1997		32. Registrar's Signature Julia Davidson-Randall			

State
Registrar

2 + u a

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21391

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANNE MAE MORRIS				2. Date of Death Month Day Year JULY 9, 1997		3. Time of Death 10:00 P.M.	
	4a. Facility Name (If not institution, give street and number) GENSIS LONG GREEN				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death n/a	
Funeral Director	5. Social Security Number 212-10-3715	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 94 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 5/29/03		9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent							
10a. State MARYLAND		10b. County BALTIMORE		10c. City, Town or Location TOWSON			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 6915 LACHLAN CIRCLE				10f. Zip Code 21239		10g. Citizen of What Country? USA		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th GRADE College (1-4 or 5+) College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) INSURANCE AGENT		16b. Kind of Business/Industry INSURANCE		
17. Father's Name (First, Middle, Last) CHARLES MORRIS				18. Mother's Name (First, Middle, Maiden Surname) EMMA KELLER				
19a. Informant's Name/Relationship (Type, Print) GEORGE T. REICHARD NEPHEW				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6915 LACHLAN CIRCLE TOWSON, MD 21239				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) LORRAINE PARK CEMETERY		Date 7/14/97		20c. Location - City or Town, State WOODLAWN, MD		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 21286				
23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Alzheimer's Type of Dementia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death 2 yrs
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Iron deficiency Anemia						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number D33897		29d. Date signed (Month, Day, Year) 7/10/97		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Vissing 4300 N. Charles St Baltimore, MD 21218								
31. Date filed (Month, Day, Year) JUL 15 1997				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours of death.

To the Funeral Director: This certificate has been signed by the attending physician and completely filled in by the funeral director; page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

5

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21392

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) Donald James Morsell				2. Date of Death Month Day Year July 9, 1997		3. Time of Death 1200p	
4a. Facility Name (If not institution, give street and number) UNIVERSITY OF MD SHOCK TRAUMA				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
5. Social Security Number 214-84-1266		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 37 Yrs.		8. Date of Birth (Month, Day, Year) MAR 14, 1960	
9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Glen Burnie	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 206 Crain Court Circle, Apt. 2B		10f. Zip Code 21061		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter		16b. Kind of Business/Industry Commercial Construction		17. Father's Name (First, Middle, Last) Donald Irvin Morsell	
18. Mother's Name (First, Middle, Maiden Surname) Helen May Leisner		19a. Informant's Name/Relationship (Type, Print) Teresa M. Morsell/Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 206 Crain Ct. Circle, Apt. 2B Glen Burnie, MD 21061		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. 7/11/97		20c. Location - City or Town, State Baltimore, MD		21. Signature of Funeral Service Licensee Dawn F. McDonald		22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. GUNSHOT WOUND WITH COMPLICATIONS Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day, Year) 6/19/97		28b. Time of Injury 11:49		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred subject was shot	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) parking lot		28f. Location (Street and Number or Rural Route Number, City or Town, State) 8005 Nolpark Court Glen Burnie, Maryland		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Dennis J. Chute, MD	
29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) July 10, 1997		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201		31. Date filed (Month, Day, Year) JUL 15 1997	

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 21393**
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ISAIAH M. McKoy				2. Date of Death Month JUNE Day 26 Year 1997		3. Time of Death 4:02 PM									
	4a. Facility Name (If not institution, give street and number) ST AGNES HOSPITAL				4b. City, Town, or Location of Death BALTIMORE, MD		4c. County of Death									
Funeral Director	5. Social Security Number 217-49-0961		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 0 Yrs.	If Under 1 Year Months 2	If Under 24 Hrs. Hours 2 Min.	8. Date of Birth (Month, Day, Year) April 13, 1997	9. Birthplace (State or Foreign Country) Maryland								
	Usual Residence of Decedent															
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
	10e. Street and Number 2408 W. Lombard				10f. Zip Code 21223		10g. Citizen of What Country? USA									
	11. Marital Status <input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black									
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A				16b. Kind of Business/Industry N/A									
	17. Father's Name (First, Middle, Last) Willie McKoy				18. Mother's Name (First, Middle, Maiden Surname) Tia Payton											
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Willie McKoy / father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2408 W. Lombard St.											
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery		Date 6/30		20c. Location - City or Town, State Landsdowne, Maryland									
	21. Signature of Funeral Service Licensee Kevin Parker				22. Name and Address of Facility Kevin A. Parker Funeral Home 3572 Frederick Ave. Baltimore, Maryland 21229											
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. MULTISYSTEM ORGAN FAILURE Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death WEEKS</td> </tr> <tr> <td>b. EXTREME PREMATURITY Due to (or as a consequence of):</td> <td>10 WEEKS</td> </tr> <tr> <td>c. _____ Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d. _____ Due to (or as a consequence of):</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. MULTISYSTEM ORGAN FAILURE Due to (or as a consequence of):	Approximate Interval Between Onset and Death WEEKS	b. EXTREME PREMATURITY Due to (or as a consequence of):	10 WEEKS	c. _____ Due to (or as a consequence of):		d. _____ Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)	a. MULTISYSTEM ORGAN FAILURE Due to (or as a consequence of):	Approximate Interval Between Onset and Death WEEKS														
	b. EXTREME PREMATURITY Due to (or as a consequence of):	10 WEEKS														
	c. _____ Due to (or as a consequence of):															
	d. _____ Due to (or as a consequence of):															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)														
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred												
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Howard J. Sirenbaum MD		29c. License number D29475		29d. Date signed (Month, Day, Year) JUNE 27, 1997										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOWARD J. SIRENBAUM, MD ST AGNES HOSPITAL 900 CATON AVE, BALTIMORE, MD																
31. Date filed (Month, Day, Year) JUL 15 1997		32. Registrar's Signature Julia Davidson-Rendell														

97 21394

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Eduardo				2. DATE OF DEATH MONTH 01 DAY 03 YEAR 97				3. TIME OF DEATH 4:30 A M										
4. SOCIAL SECURITY NUMBER 230 567 955		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12/08/15		8. BIRTHPLACE (State or Foreign Country) Cuba										
9a. FACILITY NAME (If not institution, give street and number) 35 Homehurst Lane				9b. CITY, TOWN OR LOCATION OF DEATH Elkton, MD				9c. COUNTY OF DEATH Cecil Co										
10a. STATE MD			10b. COUNTY Cecil			10c. CITY, TOWN OR LOCATION Elkton			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
10e. STREET AND NUMBER 35 Homehurst Lane				10f. ZIP CODE 21921				10g. CITIZEN OF WHAT COUNTRY? USA										
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Specify: Cuban				14. RACE — American Indian, Black, White, etc. Specify: white										
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Physician				16b. KIND OF BUSINESS/INDUSTRY Anesthesiology										
17. FATHER'S NAME (First, Middle, Last) Jose March y Barcelo						18. MOTHER'S NAME (First, Middle, Maiden Surname) Clara Alvarez-Munoz												
19a. INFORMANT'S NAME (Type/Print) Evelia M. C. March/wife				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35 Homehurst Lane, Elkton, Maryland 21921														
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)				20c. LOCATION — City or Town, State										
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald S. Wade, Director				22. NAME AND ADDRESS OF FACILITY State Anatomy Board, 655 W. Baltimore St. Baltimore, Maryland 21201														
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <table border="0"> <tr> <td>a.</td> <td>DUE TO (OR AS A CONSEQUENCE OF):</td> <td rowspan="4">3 yrs</td> </tr> <tr> <td>b.</td> <td>Adenocarcinoma of Lung</td> </tr> <tr> <td>c.</td> <td>Smoking</td> </tr> <tr> <td>d.</td> <td>DUE TO (OR AS A CONSEQUENCE OF):</td> </tr> </table>								a.	DUE TO (OR AS A CONSEQUENCE OF):	3 yrs	b.	Adenocarcinoma of Lung	c.	Smoking	d.	DUE TO (OR AS A CONSEQUENCE OF):	Approximate Interval Between Onset and Death	
a.	DUE TO (OR AS A CONSEQUENCE OF):	3 yrs																
b.	Adenocarcinoma of Lung																	
c.	Smoking																	
d.	DUE TO (OR AS A CONSEQUENCE OF):																	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)														
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO										
				28d. DESCRIBE HOW INJURY OCCURED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)										
				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)														
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																		
29b. SIGNATURE AND TITLE OF CERTIFIER James L. Sey						29c. LICENSE NUMBER 043198		29d. DATE SIGNED (Month, Day, Year) 7/3/97										
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. James Stephen Sey - 111 W. High St - Ste-103 - Elkton, MD 21921																		
31. DATE FILED (Month, Day, Year) JUL 15 1997				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall														

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: Also, the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21395

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANNA E. MEISEL				2. Date of Death Month July Day 4 Year 1997		3. Time of Death 1510P		
	4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL				4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 213-10-6010		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 92 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 17, 1904		
	9. Birthplace (State or Foreign Country) Maryland		10. Usual Residence of Decedent 10a. State Maryland 10b. County Montgomery 10c. City, Town or Location Rockville 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 9701 Viers Drive		10f. Zip Code 20850		
10g. Citizen of What Country? U.S.A.		11. Marital Status unknown <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sewing Machine Operator		16b. Kind of Business/Industry Private		17. Father's Name (First, Middle, Last) Joshua Wenzel		18. Mother's Name (First, Middle, Maiden Surname) Augusta Wenzel Meisel	
19a. Informant's Name/Relationship (Type, Print) Treva Ann Bergeron/daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1095 Montclare Drive, Sykesville, MD 21784		20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Ronald S. Wade, Director State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Congestive Heart Failure Due to (or as a consequence of): b. Arteriosclerotic Coronary Artery Disease Due to (or as a consequence of): c. Aortic Stenosis Calcification Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death 30 mins 40 years 50 years			
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Upper gastrointestinal bleeding, duodenal arteriovenous malformation, diabetes mellitus type II		23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was cause referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and Title of certifier 		29c. License number 036618		29d. Date signed (Month, Day, Year) July 5, 1997			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christopher M. Schemm, MD, 9701 Viers Drive, Rockville MD 20850		31. Date filed (Month, Day, Year) JUL 15 1997		32. Signature of Registrar 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerPhysician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21396

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BRIANNA MICHELLE NETTLES

2. Date of Death

JULY

Day

13

Year

1997

3. Time of Death

9:02 AM

4a. Facility Name (If not institution, give street and number)

The Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore city

4c. County of Death

Funeral
Director

5. Social Security Number

219-43-9004

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

2 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

Feb. 6, 1995

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Ft. Meade

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8028 E Leslie Road

10f. Zip Code

20755

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
0

College (1-4 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

David C. Nettles

18. Mother's Name (First, Middle, Maiden Surname)

Deana M. Mitchel

19a. Informant's Name/Relationship (Type, Print)

David C. Nettles/Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8028 E Leslie Road, Ft. Meade, MD 21755

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory

Date

7-16-97

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Director/Licensee

Stephan D. Lohrmann

22. Name and Address of Facility

CAFA- Stephan D. Lohrmann, P.A.

8717 Green Pastures Drive, Baltimore, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. respiratory failure
Due to (or as a consequence of):

2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. legionella pneumonia
Due to (or as a consequence of):

2 weeks

c. parainfluenza pneumonia
Due to (or as a consequence of):

2 weeks

d. histiocytosis

one year

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jennifer J. Schuette

29c. License number

D51118

29d. Date signed (Month, Day, Year)

July 13, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Jennifer J. Schuette 600 N. Wolfe Street, Johns Hopkins Hospital, Baltimore, MD 21207

31. Date filed (Month, Day, Year)

JUL 15 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

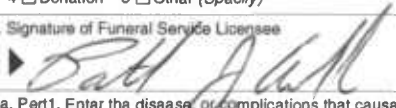


To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be forwarded for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21397
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Norris Sr.				2. Date of Death Month Day Year July 12 1997		3. Time of Death 6:30 PM				
	4a. Facility Name (If not institution, give street and number) Meridian Nursing Home Spa Creek				4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel				
Funeral Director	5. Social Security Number 218-05-7018		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug 23 1916		9. Birthplace (State or Foreign Country) Brooklyn, NY		
	Usual Residence of Decedent										
10a. State MD			10b. County Anne Arundel		10c. City, Town or Location Crownsville			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 501 Palisades					10f. Zip Code 21032		10g. Citizen of What Country? U.S.A.				
11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 3					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Contractor - Diver			16b. Kind of Business/Industry Marine Construction			
17. Father's Name (First, Middle, Last) Clifford Norris					18. Mother's Name (First, Middle, Maiden Summa) Laura Fisher						
19a. Informant's Name/Relationship (Type, Print) John H. Norris, Jr. /Son					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 Palisades, Crownsville, MD 21032						
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Louden Park			Data 7/15/97		20c. Location - City or Town, State Baltimore, MD			
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Hardesty Funeral Home 12 Ridgely Avenue, Annapolis, MD 21401						
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. CONGESTIVE HEART FAILURE Due to (or as a consequence of): b. CORONARY ARTERY DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death YEARS 7 TEN YEARS	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC ATRIAL FIBRILLATION METASTATIC PROSTATE CANCER										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier  MD MPH			29c. License number D 38328		29d. Date signed (Month, Day, Year) JULY 14, 1997			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARY R CLANCE 180 ADMIRAL COCHRANE DR ANNAPOLIS MD 21401											
31. Date filed (Month, Day, Year) JUL 15 1997			32. Registrar's Signature  MD 21401								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-e show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerState
Registrar

97 21398

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <i>Katherine M. Paul</i>				2. DATE OF DEATH MONTH DAY YEAR <i>July 12 1997</i>		3. TIME OF DEATH <i>10:55 P M</i>	
4. SOCIAL SECURITY NUMBER <i>213-20-6672</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) <i>90</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Dec. 25, 1906</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Baltimore</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Frederick Villa Nursing Home</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>	
9c. COUNTY OF DEATH <i>Baltimore</i>				RESIDENCE OF DECEASED			
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Baltimore</i>		10c. CITY, TOWN OR LOCATION <i>Catonsville</i>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>1795 Westchester Avenue</i>				10f. ZIP CODE <i>21228</i>		10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>white</i>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10</i>		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>homemaker</i>		16b. KIND OF BUSINESS/INDUSTRY <i>own home</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Edward Schnebelen</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Louise Bolm</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Joyce Davis, niece</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1795 Westchester Avenue Catonsville, MD 21228</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Loudon Park Cemetery</i>		20c. LOCATION — City or Town, State <i>Baltimore, Maryland</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Paul W. Hogan</i>				22. NAME AND ADDRESS OF FACILITY <i>Ambrose Funeral Home, Inc. Arbutus 1328 Sulphur Spring Road 21228</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cancer Rectum</i>						DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						DUE TO (OR AS A CONSEQUENCE OF):	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <i>Frederick Villa</i>		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Davidson-Randall</i>				29c. LICENSE NUMBER <i>D15872</i>		29d. DATE SIGNED (Month, Day, Year) <i>July 13 1997</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Harold B. Buss MD 7220 Park Heights Ave Baltimore, Md 21206</i>							
31. DATE FILED (Month, Day, Year) <i>JUL 15 1997</i>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21399

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Galina

Polishchuk

2. Date of Death

Month

Day

Year

July

10

1997

3. Time of Death

0600 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Northwest Hospital Center

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

5. Social Security Number

218-41-1649

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

SEPT. 25, 1929

9. Birthplace (State or Foreign Country)

RUSSIA

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

OWINGS MILLS

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

917 JOSHUA TREE CT.

10f. Zip Code

21117

10g. Citizen of What Country?

RUSSIA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOUSEKEEPER

16b. Kind of Business/Industry

HOTEL

17. Father's Name (First, Middle, Last)

VASILY

GUSLAVSKY

18. Mother's Name (First, Middle, Maiden Surname)

MOTYA

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

MRS. JANNA OSTROVSKY (DAUG.)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

917 JOSHUA TREE CT. OWINGS MILLS, MD 21117

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

DRUID RIDGE

Date

7/11/97

20c. Location - City or Town, State

PIKESVILLE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 REISTERSTOWN RD., PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Anoxic brain injury

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

hours/days

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Septic shock

Due to (or as a consequence of):

hours/days

c. Urrosepsis

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Parkinson's d., acute renal failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D. Roggen MD

29c. License number

D 35844

29d. Date signed (Month, Day, Year)

July 10, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D. Roggen 5406 Old Court Rd - Randallstown MD 21133

31. Date filed (Month, Day, Year)

JUL 15 1997

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at office.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

The Hospital or Attending Physician: The law requires that the death certificate be executed in 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be dated for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21400

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DR. JESSE PATT				2. Date of Death Month JULY Day 11 Year 1997		3. Time of Death 12:12pm		
	4a. Facility Name (If not institution, give street and number) LORIEN NURSING HOME				4b. City, Town, or Location of Death COLUMBIA		4c. County of Death HOWARD		
Funeral Director	5. Social Security Number 109-36-5942		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) NOV. 23, 1908		
	9. Birthplace (State or Foreign Country) NEW YORK		10a. State MARYLAND		10b. County HOWARD		10c. City, Town or Location COLUMBIA		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 6334 CEDAR LANE		10f. Zip Code 21044		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PHYSICIAN		16b. Kind of Business/Industry MEDICINE					
17. Father's Name (First, Middle, Last) ARTHUR PATT				18. Mother's Name (First, Middle, Maiden Surname) BESSIE KATZ					
19a. Informant's Name/Relationship (Type, Print) DR. PHILIP PATT (son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11412 elfstone way COLUMBIA, MD 21044					
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) STAR OF DAVID		Date 7/13/97		20c. Location - City or Town, State N. LAUDERDALE, FL			
21. Signature of Funeral Service Licensee <i>Jay Alay Lewis</i>				22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pulmonary Embolism Due to (or as a consequence of): b. Atrial fibrillation Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last {				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive heart failure Dementia				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Jawob Chiu MD</i>		29c. License number D50973		29d. Date signed (Month, Day, Year) July 11, 1997			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patuxent Medical Group Two Knoll North DR. Columbia MD 21045				31. Date filed (Month, Day, Year) JUL 15 1997				32. Registrar's Signature <i>Julia Davidson-Randall</i>	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

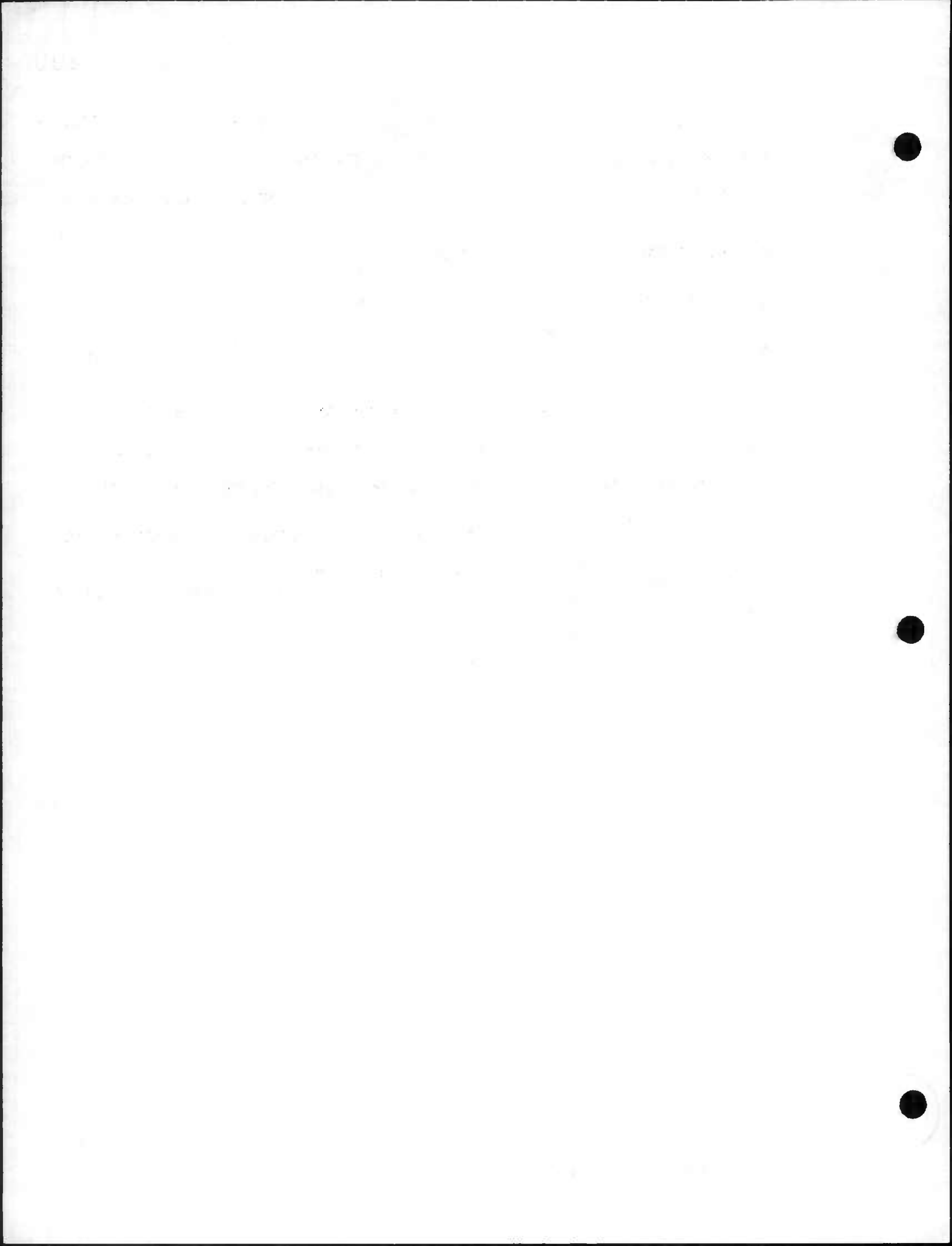
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21401

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Steven Keith Parker						2. Date of Death Month July Day 09 Year 1997		3. Time of Death 4:00 P	
	4a. Facility Name (If not institution, give street and number) RT. 24						4b. City, Town, or Location of Death FOREST HILL		4c. County of Death HARFORD	
Funeral Director	5. Social Security Number 167-44-0725		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 37 Yrs.		8. Date of Birth (Month, Day, Year) 10/10/59		9. Birthplace (State or Foreign Country) PA	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10e. State PA		10b. County Chester		10c. City, Town or Location Coatesville				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 100 Birchview Drive				10f. Zip Code 19320		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1977-1978		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH College (1-4or 5+)				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Lawn Care			16b. Kind of Business/Industry Self Employed		
	17. Father's Name (First, Middle, Last) Roy H. Parker						18. Mother's Name (First, Middle, Maiden Surname) Annette M. Hess			
	19a. Informant's Name/Relationship (Type, Print) Susan Parker / Step-mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 701 W. First Ave.; Parkesburg, PA 19460					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Morris Cemetery		20c. Location - City or Town, State 7/14/97 Phoenixville, PA			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Johnson Funeral Home 8521 Loch Raven Blvd.; Towson, MD 21286					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Multiple Injuries Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) MVA										
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined										
28e. Date of Injury (Month, Day Year) 7/9/97 28b. Time of Injury 3:15 PM 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
28d. Describe how injury occurred Motorcycle collision										
28f. Location (Street and Number or Rural Route Number, City or Town, State) Rt 24 Harford Co, md										
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 										
29c. License number OCME										
29d. Date signed (Month, Day, Year) July 10, 1997										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chate, md 111 Penn Street, Baltimore, Maryland 21201										
31. Date filed (Month, Day, Year) JUL 15 1997										
32. Registrar's Signature 										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this death certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

97 21402

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Calvin J. Paige</i>				2. DATE OF DEATH MONTH <i>07</i> DAY <i>10</i> YEAR <i>1997</i>		3. TIME OF DEATH <i>11:55A</i>	
4. SOCIAL SECURITY NUMBER <i>212-30-7800</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>63</i> YRS.		7. DATE OF BIRTH MONTH <i>02</i> DAY <i>19</i> YEAR <i>1934</i>	
8. BIRTHPLACE (State or Foreign) <i>MARYLAND</i>				9a. FACILITY NAME (If not institution, give street and number) <i>CATON MANOR NURSING HOME</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTIMORE</i>	
9c. COUNTY OF DEATH <i>N/A</i>				10a. STATE <i>MD</i>		10b. COUNTY <i>N/A</i>	
10c. CITY, TOWN OR LOCATION <i>BALTIMORE</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>101 S. MORLEY ST.</i>	
10f. ZIP CODE <i>21229</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>KOREAN</i>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>BLACK</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>N/A</i> College (1-4 or 5+) <i>N/A</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>LABORER</i>		16b. KIND OF BUSINESS/INDUSTRY <i>STEEL</i>	
17. FATHER'S NAME (First, Middle, Last) <i>DANIEL J. PAIGE</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>MARTHA PAIGE</i>			
19a. INFORMANT'S NAME (Type/Print) <i>EVELYN PAIGE</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>101 S. MORLEY ST. BALT, MD 21229</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, funeral home, or other place) <i>GARRISON FOREST</i> DATE <i>7/10/97</i>		20c. LOCATION — City or Town, State <i>WINDY MILLS MD</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FUNERAL HOME <i>GARY P. MARCHE FUNERAL HOME, 270 FREDERICK PASS BALT, MD 21229</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Pneumonia</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>Aspirin</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Cerebrovascular Accident</i> DUE TO (OR AS A CONSEQUENCE OF): c. d. Approximate interval Between Onset and Death <i>1 week</i> <i>1 week</i> <i>5 days</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>William M. Attending Doctor</i>				29c. LICENSE NUMBER <i>D 21684</i>		29d. DATE SIGNED (Month, Day, Year) <i>7-10-97</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>C.V. CYRIAC-M-O 8109 RITCHIE HWY, PASADENA, MD 21122</i>							
31. DATE FILED (Month, Day, Year) <i>JUL 15 1997</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 21403

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) Ann McComas Phillips				2. Date of Death Month Day Year July 12, 1997		3. Time of Death 1915													
4a. Facility Name (If not institution, give street and number) St. Agnes Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A													
5. Social Security Number 217-94-5764		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 35 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 08/20/1961	9. Birthplace (State or Foreign Country) MD												
Usual Residence of Decedent																			
10a. State Md		10b. County Baltimore		10c. City, Town or Location Catonsville		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No													
10e. Street and Number 15 Arkla Court				10f. Zip Code 21228		10g. Citizen of What Country? USA													
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white													
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home													
17. Father's Name (First, Middle, Last) Robert Mellendick				18. Mother's Name (First, Middle, Maiden Surname) Carolyn McComas															
19a. Informant's Name/Relationship (Type, Print) Terry Phillips/Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Arkla Court, Catonsville, Md. 21228															
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Vet Cem		Date 7/16		20c. Location - City or Town, State Owings Mills, Md													
21. Signature of Funeral Service Licensee <i>Peter S. Delton</i>				22. Name and Address of Facility Sterling Ashton Funeral Home, Inc 736 Edmondson Avenue, Balto, Md. 21228															
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Asystole</td> <td rowspan="4"> Due to (or as a consequence of): Sepsis Infected decubitus ulcer </td> <td rowspan="4"> Due to (or as a consequence of): Many months </td> <td rowspan="4"> Approximate Interval Between Onset and Death few minutes days </td> </tr> <tr><td>b.</td><td></td></tr> <tr><td>c.</td><td></td></tr> <tr><td>d.</td><td></td></tr> </table>								Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Asystole	Due to (or as a consequence of): Sepsis Infected decubitus ulcer	Due to (or as a consequence of): Many months	Approximate Interval Between Onset and Death few minutes days	b.		c.		d.	
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Asystole	Due to (or as a consequence of): Sepsis Infected decubitus ulcer	Due to (or as a consequence of): Many months	Approximate Interval Between Onset and Death few minutes days														
	b.																		
	c.																		
	d.																		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Scoliosis Paraplegia						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown													
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No													
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No													
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No													
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred															
		28f. Location (Street and Number or Rural Route Number, City or Town, State)																	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																			
29b. Signature and title of certifier <i>ER Attending</i>				29c. License number D40356		29d. Date signed (Month, Day, Year) JULY 12, 1997													
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NENEUSA T. NAVARRO 900 Cedar Ave. Baltimore, Maryland 21229																			
31. Date filed (Month, Day, Year) JUL 15 1997				32. Registrar's Signature <i>Julia Madison-Randall</i>															

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

NAME: ANN M. PHILLIPS

5

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21404

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARGARET ANIS PUGH				2. Date of Death Month Day Year July 11, 1997		3. Time of Death 5:57 a.m.	
	4a. Facility Name (If not institution, give street and number) Stella Maris Hospice				4b. City, Town, or Location of Death Baltimore County		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 218-78-4582		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 39 Yrs.		8. Date of Birth (Month, Day, Year) May 15, 1958	
	9. Birthplace (State or Foreign Country) Baltimore, Maryland		10a. State Maryland		10b. County Harford		10c. City, Town or Location Whiteford	
To Be Completed by Funeral Director	10e. Street and Number 4090 Prospect Road		10f. Zip Code 21160		10g. Citizen of What Country? USA		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Graphic Designer		16b. Kind of Business/Industry Pugh Design			
	17. Father's Name (First, Middle, Last) Raymond Milton Byrd				18. Mother's Name (First, Middle, Maiden Surname) Jeannine Louise Kling			
To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print) Randy G. Pugh (Husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4090 Prospect Road Whiteford, Maryland 21160			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cemetery		20c. Date July 14, 1997		20d. Location - City or Town, State Baltimore, Maryland	
To Be Completed by Funeral Director	21. Signature of Funeral Service Licensee Deborah Chojnacki				22. Name and Address of Facility Lassahn Funeral Home, Inc. 7401 Belair Road Baltimore, Maryland 21236-4625			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Metastatic cervical cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death 2 yr. 7 mos.			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) HOSPICE	
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how Injury occurred			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number 7 15504		29d. Date signed (Month, Day, Year) 7 11 97	
	29b. Signature and title of certifier John E. Nakhuda							
State Registrar	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DR. EDDIE NAKHUDA 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093							
	31. Date filed (Month, Day, Year) JUL 15 1997				32. Registrar's Signature John E. Nakhuda			

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21405

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) IRENE R. PLOCH		2. Date of Death Month 7 Day 11 Year 97		3. Time of Death 5:12am
	4a. Facility Name (If not institution, give street and number) HERITAGE NURSING HOME		4b. City, Town, or Location of Death N/A		4c. County of Death Baltimore
Funeral Director	5. Social Security Number 177 12 0133	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) 3/6/20		9. Birthplace (State or Foreign Country) PA		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State MD	10b. County N/A	10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 335 S. Chester Street		10f. Zip Code 21231		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		
	16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales		16b. Kind of Business/Industry Clothing		
	17. Father's Name (First, Middle, Last) Alexander Yablonski		18. Mother's Name (First, Middle, Maiden Surname) Beatrice Surdock		
	19a. Informant's Name/Relationship (Type, Print) John Ploch/Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 335 S. Chester Street Baltimore MD 21231		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Rosary Cemetery		20c. Location - City or Town, State 7/14 Baltimore MD
	21. Signature of Funeral Service Licensee Kathleen Weber CFSP		22. Name and Address of Facility David J. Weber Funeral Home 401 S. Chester St. Baltimore MD 21231		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last a. CARDIO PULMONARY ARREST Due to (or as a consequence of): b. PSEUDOMYXOMATOUS PERITONEI Due to (or as a consequence of): c. CHRONIC OBSTRUCTIVE PULMONARY DISEASE Due to (or as a consequence of): d. CARCINOMA OF OVARY					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ABDOMINAL FISTULA					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide					
28a. Date of Injury (Month, Day Year)					
28b. Time of Injury M					
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No					
28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Sarinder K. Tuli					
29c. License number D27188					
29d. Date signed (Month, Day, Year) 7/12/97					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sarinder K. Tuli & Markel Place Dundalk MD 21222					
31. Date filed (Month, Day, Year) JUL 15 1997					
32. Registrar's Signature John Davidson-Randall					

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed, it will be filed in by the funeral director; page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

21

State
Registrar

97-3801-510
B.K.S
UNK.97-153
TYONDA ROLAND

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21406

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) TYONDA ROLAND				2. Date of Death Month JULY Day 11, Year 1997		3. Time of Death 12:17AM							
	4e. Facility Name (If not institution, give street and number) 1200BLK. CHURCH STREET				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A							
Funeral Director	5. Social Security Number 213-96-3820		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 16 Yrs.		8. Date of Birth (Month, Day, Year) 8/11/1980		9. Birthplace (State or Foreign Country) Maryland					
	Usual Residence of Decedent													
To Be Completed by Funeral Director	10a. State MD		10b. County BALTIMORE		10c. City, Town or Location DUNDALK				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
	10e. Street and Number 2031 PAULETTE ROAD, #203				10f. Zip Code 21222		10g. Citizen of What Country? U.S.A.							
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4or 5+) N/A				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A			16b. Kind of Business/Industry N/A						
	17. Father's Name (First, Middle, Last) Mark Roland				18. Mother's Name (First, Middle, Maiden Surname) Rochelle Baker									
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Karen Baker				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1641 Aisquith Street, Baltimore, MD 21202									
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEMETERY		Date 7/17		20c. Location - City or Town, State BALTIMORE, MARYLAND							
	21. Signature of Funeral Service Licensee <i>Leroy O. Dyett</i>				22. Name and Address of Facility LEROY O. DYETT & SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE., BALTO. 21207									
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Multiple Injuries Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? XX Yes 2 <input type="checkbox"/> No										26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) ROADWAY			
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 7-11-97		28b. Time of Injury 1201 M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Passenger in motorcycle accident					
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) STREET				28f. Location (Street and Number or Rural Route Number, City or Town, State) 1200 BLK. Church St.							
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. XX <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) JULY 11, 1997	
	29b. Signature and title of certifier <i>J. Laron Locke</i>													
State Registrar	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201										31. Date filed (Month, Day, Year) JUL 15 1997			

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21407

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Genevieve Katherine Russell Root				2. Date of Death Month July Day 12 Year 1997		3. Time of Death 5:50 A.M.	
	4a. Facility Name (If not institution, give street and number) Manor Care-Ruxton				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 214-36-9872		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) Sept 3, 1910	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Parkville	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 3004 4th Avenue		10f. Zip Code 21234		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) n/a		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Librarian Assistant		16b. Kind of Business/Industry Education			
	17. Father's Name (First, Middle, Last) Leroy Russell				18. Mother's Name (First, Middle, Maiden Surname) Melanie Mercer			
	19a. Informant's Name/Relationship (Type, Print) R. Jeffery Root/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3004 4th Avenue, Baltimore, MD 21234			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremation Service		20c. Location - City or Town, State 7/14/97 Hampstead, Maryland			
	21. Signature of Funeral Service Licensed Bryan W. Clary				22. Name and Address of Facility Lemmon Funeral Home 10 W. Padonia Road, Timonium, MD 21093			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. Severe malnutrition</p> <p>b. Colon Cancer</p> <p>c. </p> <p>d. </p> </div> <div style="width: 35%;"> <p>Approximate Interval Between Onset and Death</p> <p>6 Months</p> <p>2 years</p> </div> </div>							
	<p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p>23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown</p> <p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>							
<p>25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)</p> <p>27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined</p> <p>28a. Date of Injury (Month, Day Year) 7-13-97</p> <p>28b. Time of Injury M</p> <p>28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>28d. Describe how injury occurred</p> <p>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</p> <p>28f. Location (Street and Number or Rural Route Number, City or Town, State)</p>								
<p>29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</p> <p>29b. Signature and title of certifier Dr. G. J. [Signature]</p> <p>29c. License number 542736</p> <p>29d. Date signed (Month, Day, Year) 7-13-97</p>								
<p>30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 Osler Drive Towson Md 21204 - Dr. Ayman Akkad</p> <p>31. Date filed (Month, Day, Year) JUL 15 1997</p> <p>32. Registrar's Signature Julia Davidson-Randall</p>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21408

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Anna E. Rolka				2. Date of Death Month Day Year July 10 1997				3. Time of Death 8:00 A.M.	
	4a. Facility Name (If not institution, give street and number) 3557 Elmora Ave.				4b. City, Town, or Location of Death Baltimore City				4c. County of Death N/A	
Funeral Director	5. Social Security Number 219-03-3445		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) 8/2/1912		9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore City				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 3557 Elmora Ave.				10f. Zip Code 21213		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) N/A				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesperson		16b. Kind of Business/Industry Retail			
	17. Father's Name (First, Middle, Last) John Sienkewich				18. Mother's Name (First, Middle, Maiden Surname) Catherine Unk.					
	19a. Informant's Name/Relationship (Type, Print) Anthony Rolka				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3557 Elmora Ave. Baltimore, MD 21213					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart of Jesus		20c. Location - City or Town, State 7/12/97 Baltimore Cnty., MD					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility B. Dabrowski & Son Funeral Home 2818 E. Baltimore St. Baltimore, MD 21224					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. coronary artery disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last { ventricular aneurysm ischemic cardiomyopathy									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ventricular aneurysm ischemic cardiomyopathy									
Physician /Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier Victoria Vanik MD				29c. License number D32381		29d. Date signed (Month, Day, Year) 7/11/97			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VICTORIA VANIK M.D. 3400 Brehms Lane Balt MD 21213									
	31. Date filed (Month, Day, Year) JUL 15 1997									
32. Registrar's Signature 										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21409

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOSEPH P. SMITH				2. Date of Death Month JULY Day 8 Year 1997				3. Time of Death 7:40 AM				
	4e. Facility Name (If not institution, give street and number) IVY HALL NURSING HOME				4b. City, Town, or Location of Death Baltimore County				4c. County of Death Baltimore				
Funeral Director	5. Social Security Number 219-01-4579		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 80		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Year) Dec. 8, 1916		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent												
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Overlea/Fullerton				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	10e. Street and Number 3 East Elm Avenue				10f. Zip Code 21206				10g. Citizen of What Country? USA				
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th grade College (1-4 or 5+) N/A				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Painter				16b. Kind of Business/Industry Self-Employed				
	17. Father's Name (First, Middle, Last) Charles Louis Smith				18. Mother's Name (First, Middle, Maiden Surname) Genevieve L. Eichelberger								
To Be Completed by Physician/Medical Examiner	19e. Informant's Name/Relationship (Type, Print) Mrs. Peggy A. Sadowski				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3403 Upton Circle Baltimore, Md. 21234								
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cemetery 7-11-97 Baltimore, Md.				Date		20c. Location - City or Town, State				
	21. Signature of Funeral Service Licensee <i>Deborah Sadowski</i>				22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sudden Stroke from Disease Due to (or as a consequence of): b. Cerebral aneurysm Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):										Approximate Interval Between Onset and Death Hours years		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred				
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
	29b. Signature and title of certifier <i>Dr. M. J. ...</i>				29c. License number 208358				29d. Date signed (Month, Day, Year) 7/9/97				
State Registrar	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) GRACIE Y. PATRICK 8903 HARTWOOD ROAD BALTIMORE 21234												
	31. Date filed (Month, Day, Year) JUL 15 1997				32. Registrar's Signature <i>Davidson-Randall</i>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21410

Certificate of Death

Reg. No.

ORVILLE W. SHIRLEY

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) ORVILLE WILSON SHIREY				2. Date of Death Month Day Year JULY 10 1997		3. Time of Death 7:23 PM			
4a. Facility Name (If not institution, give street and number) GARRETT MEMORIAL HOSPITAL				4b. City, Town, or Location of Death OAKLAND		4c. County of Death GARRETT			
5. Social Security Number 215-54-7525		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 45 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 10, 1952			
9. Birthplace (State or Foreign Country) Maryland									
Usual Residence of Decedent									
10a. State TN		10b. County Davidson		10c. City, Town or Location Antioch		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 2972 Mossdale Drive				10f. Zip Code 37013		10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Editorial Coordinator		16b. Kind of Business/Industry Newspaper Printing			
17. Father's Name (First, Middle, Last) Orville C. Shirey				18. Mother's Name (First, Middle, Maiden Surname) Maud Wilson					
19a. Informant's Name/Relationship (Type, Print) Susan Shirey/ Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2972 Mossdale Dr., Antioch, TN 37013					
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery		Date 7-12		20c. Location - City or Town, State Nashville, TN			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Henry W. Jenkins & Sons 4905 York Rd., Baltimore, MD 21212					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pulmonary Emboli Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JULY 11, 1997			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. LARON LOCKE 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) JUL 15 1997				32. Registrar's Signature 					

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21411

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Catherine Schwind

2. Date of Death

Month Day Year
July 13, 1997

3. Time of Death

9:05am

4e. Facility Name (If not institution, give street and number)

703 Chapel Ridge Road

4b. City, Town, or Location of Death

Lutherville

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

212-03-6587

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug 2, 1907

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Lutherville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

703 Chapel Ridge Road

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: White15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
10College (1-4 or 5+)
n/a16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Telephone Operator

16b. Kind of Business/Industry

Communications

17. Father's Name (First, Middle, Last)

John M. Jones

18. Mother's Name (First, Middle, Maiden Surname)

Mary Elizabeth Miller

19a. Informant's Name/Relationship (Type, Print)

Oma Ellis/Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

703 Chapel Ridge Road, Lutherville, MD 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hereford Baptist Cem.

Date

7/16/97

20c. Location - City or Town, State

Hereford, Maryland

21. Signature of Funeral Service Licensee

Bryan W. Clary

22. Name and Address of Facility

Lemmon Funeral Home
10 W. Padonia Road, Timonium, MD 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARREST

Due to (or as a consequence of):

b. HYPERTENSION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SIP CARDIOVASCULAR ACCIDENT.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dominick Memoli, MD

29c. License number

D41141

29d. Date signed (Month, Day, Year)

7/14/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dominick Memoli, MD 9 Schilling Road, Hunt Valley, Maryland 21030

31. Date filed (Month, Day, Year)

JUL 15 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Registrar: The law requires that the death certificate be executed with the Registrar's signature. To the Medical Examiner: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

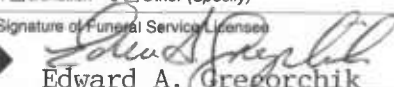
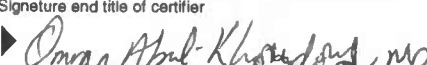
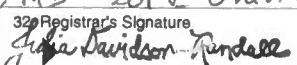
Medical Certification: To Be Completed by Physician/Medical Examiner

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 21412**
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lavern Cecelia Smithell						2. Date of Death Month July Day 10 Year 1997		3. Time of Death 02:31 AM	
	4a. Facility Name (If not institution, give street and number) Union Memorial Hospital						4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 212-36-2246		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 58 Yrs.		8. Date of Birth (Month, Day, Year) AUG 6, 1938		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10e. State MD		10b. County Anne Arundel		10c. City, Town or Location Glen Burnie				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 6435 Union Court				10f. Zip Code 21061		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager			16b. Kind of Business/Industry Tavern			
	17. Father's Name (First, Middle, Last) Stanley Griffith						18. Mother's Name (First, Middle, Maiden Surname) Eleanor Zobel			
To Be Completed by Physician/Medical Examiner	19e. Informant's Name/Relationship (Type, Print) Charles W. Smithell/husband						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6435 Union Court Glen Burnie, MD 21061			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. 7/10/97		Date 7/10/97		20c. Location - City or Town, State Baltimore, MD			
	21. Signature of Funeral Service Licensed  Edward A. Gregorchik		22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Due to (or as a consequence of):</p> <p>Due to (or as a consequence of):</p> <p>Due to (or as a consequence of):</p> <p>Due to (or as a consequence of):</p> </div> <div style="width: 35%;"> <p>Approximate Interval Between Onset and Death</p> <p>2 days</p> <p>3 days</p> <p>2 days</p> <p>10 years</p> </div> </div>									
	<p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p>23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown</p> <p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  Omeran Arul-Khondoud, MD		29c. License number AT 2438946		29d. Date signed (Month, Day, Year) July 10 1997				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) OMRAN ARUL-KHONDUD, MD 201 E Univ. Parkway Baltimore, MD 21218										
31. Date filed (Month, Day, Year) JUL 15 1997		32. Registrar's Signature  Julia Davidson-Rendell								

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician
/Medical
Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21413

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Isabelle Smith</i>				2. Date of Death Month <i>July</i> Day <i>2</i> Year <i>97</i>				3. Time of Death <i>12:35 P</i>	
	4a. Facility Name (If not institution, give street and number) <i>Villa St. Michael</i>				4b. City, Town, or Location of Death <i>Baltimore</i>				4c. County of Death <i>Baltimore City</i>	
Funeral Director	5. Social Security Number <i>117-12-9313</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>78</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>Feb. 2, 1919</i>		9. Birthplace (State or Foreign Country) <i>Pennsylvania</i>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <i>Maryland</i>		10b. County <i>Anne Arundel</i>		10c. City, Town or Location <i>Glen Burnie</i>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <i>18 Jackson Avenue</i>				10f. Zip Code <i>21061</i>		10g. Citizen of What Country? <i>U.S.A.</i>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>9</i> College (1-4or 5+) <i>0</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Sales Clerk</i>			16b. Kind of Business/Industry <i>Department Store</i>		
	17. Father's Name (First, Middle, Last) <i>Albert Cioccia</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Pasqualina Basilone</i>					
	19a. Informant's Name/Relationship (Type, Print) <i>Lill Miller/daughter</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>7012 Bexhill Road, Baltimore, Maryland 21207</i>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State			
	21. Signature of Funeral Service Licensee <i>Ronald S. Wade, Director</i>				22. Name and Address of Facility <i>State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201</i>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>Acute Myocardial Infarction</i> Due to (or as a consequence of):								Approximate Interval Between Onset and Death <i>10 min</i>	
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>PERIPHERAL VASCULAR DISEASE</i> <i>SACRAL DECUBITI</i> <i>DEPRESSION</i>									
23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>Jasneem Lakhani MD</i>				29c. License number <i>22820</i>		29d. Date signed (Month, Day, Year) <i>7/3/97</i>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>7220 PARK HEIGHTS AVE BALTO MD 21208 / JASNEEM LAKHANI</i>										
31. Date filed (Month, Day, Year) <i>JUL 15 1997</i>				32. Registrar's Signature <i>Julia Anderson-Hendall</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21414

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

KATHRYN F. STURM

2. Date of Death

JULY

Day

Year

3. Time of Death

11 20 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

SAINT JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

219-18-0869

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

SEPT 26, 1910

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE CO. MARYLAND

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

2822 EMERALD ROAD

10f. Zip Code

21234

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (14 or 5+)

N/A

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

PAUL FISCHER

18. Mother's Name (First, Middle, Maiden Surname)

Emma weitzel

19a. Informant's Name/Relationship (Type, Print)

MARGARET P. DENNIS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2825 WILLOUGHBY RD, BALTIMORE MD 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Data

20c. Location - City or Town, State

MORELAND CEMETERY 7/16/97 BALTIMORE, MD

21. Signature of Funeral Service Licensee

Jody D. Smith

22. Name and Address of Facility

HARTLEY Miller Funeral Home

7527 Harford RD BALTIMORE, MD 21234

23a. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SUBDURAL Hematoma
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 Hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Francis Khoo

29c. License number

D30263

29d. Date signed (Month, Day, Year)

7-13-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

FRANCIS KHOO, MD 7620 YORK ROAD, TOWSON, MD 21204

31. Date filed (Month, Day, Year)

JUL 15 1997

Registrar's Signature

John Davidson-Rendell

State
Registrar

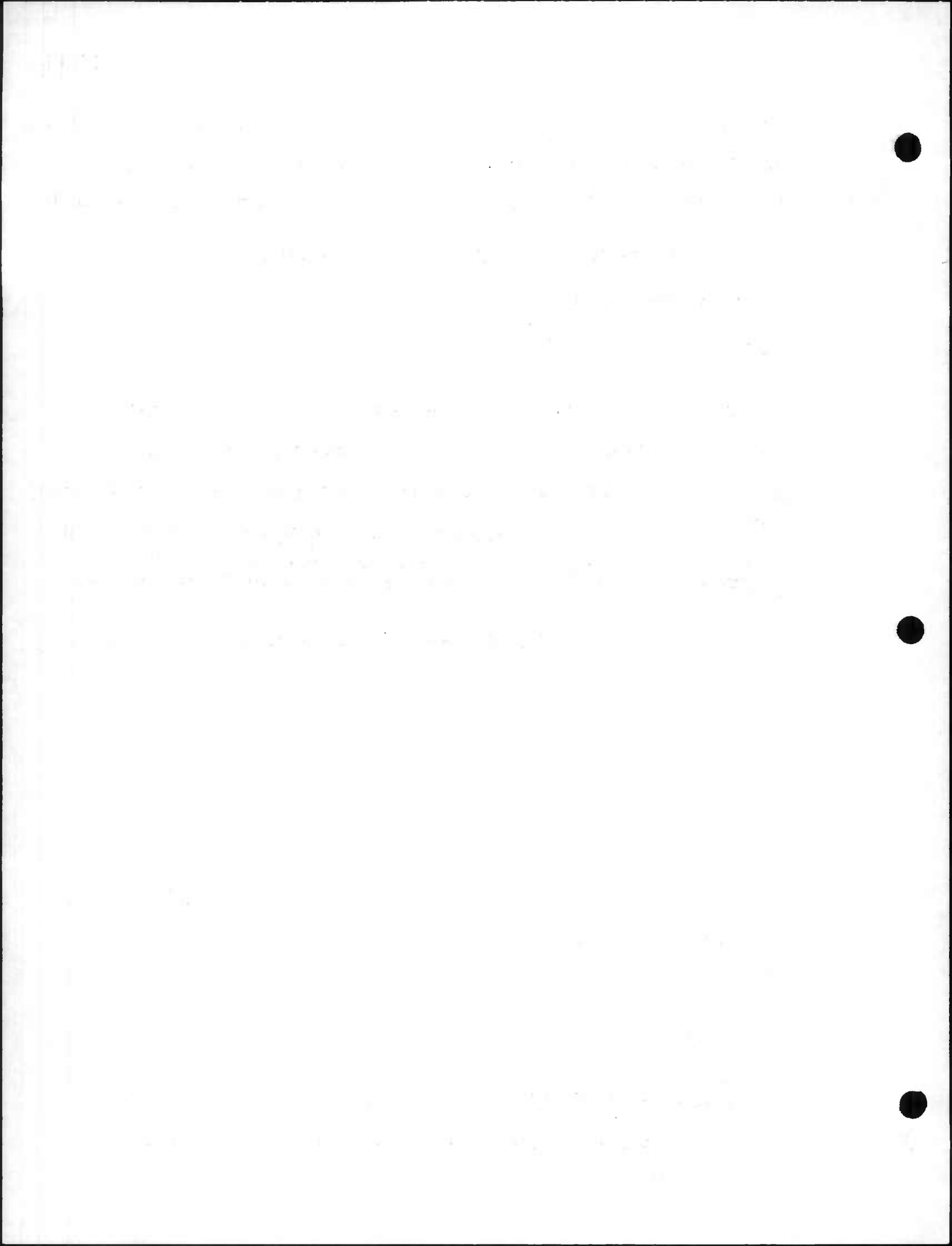
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed, fill in the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21415

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HILDA MARGARET TEWS		2. Date of Death Month Day Year JULY 9, 1997		3. Time of Death 3:00 AM
	4a. Facility Name (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSN		4b. City, Town, or Location of Death GLEN BURNIE		4c. County of Death ANNE ARUNDEL
Funeral Director	5. Social Security Number 214-20-1329	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	8. Date of Birth (Month, Day, Year) Aug. 21, 1907	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State Maryland	10b. County Anne Arundel	10c. City, Town or Location Pasedena		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 409 Dobbins Lane		10f. Zip Code 21122		10g. Citizen of What Country? United States
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No, Specify:
	14. Race - American Indian, Black, White, etc. Specify: white		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (14 or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker		16b. Kind of Business/Industry own home		
	17. Father's Name (First, Middle, Last) John A. Schwartz		18. Mother's Name (First, Middle, Maiden Surname) Carrie Tucker		
	19a. Informant's Name/Relationship (Type, Print) Joan Ann Sebald, G Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 409 Dobbins Lane Pasedena, Maryland 21122		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery		20c. Location - City or Town, State 7/11 Baltimore, Maryland
	21. Signature of Funeral Service Licensee [Signature]		22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Road 21227		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. SEPTICEMIA Due to (or as a consequence of): b. MULTI-ORGAN FAILURE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 3 days 3 days		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
	29b. Signature and title of certifier [Signature] MD		29c. License number D 43977		29d. Date signed (Month, Day, Year) 7/9/97
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GAYLEN BREUNST. 301 HOSPITAL DRIVE. GLEN BURNIE. MD 21061				
	31. Date filed (Month, Day, Year) JUL 15 1997		32. Registrar's Signature [Signature]		

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21416

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Curtis

Thomas

2. Date of Death

Month

Day

Year

July

8, 1997

3. Time of Death

9:40 AM

Funeral
Director

4e. Facility Name (If not institution, give street and number)

Joseph Ritchie Hospice

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

5. Social Security Number

213-80-0393

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

38

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Sept. 16, 1958

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Baltimore City

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

828 N. Eutaw Street

10f. Zip Code

21201

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates:

unknown

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

unknown

unknown

16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

unknown

16b. Kind of Business/Industry

unknown

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19e. Informant's Name/Relationship (Type, Print)

unknown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

unknown

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☒ Other (Specify) in state20b. Place of Disposition (Name of
cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore Street
Baltimore, Maryland 2120123a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)e. Respiratory Arrest
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

5 min

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Acquired Immuno Deficiency Syndrome (AIDS)
Due to (or as a consequence of):

6 months

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24e. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury et
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner as stated.

29b. Signature and title of certifier

Joseph H. Stephens MD

29c. License number

D11457

29d. Date signed (Month, Day, Year)

7/8/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1616 Bottom St. Baltimore MD 21217

State
Registrar

31. Date filed (Month, Day, Year)

JUL 15 1997

32. Registrar's Signature

Julia Gordon-Rodriguez

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached and filed as the initial-transit office.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21417

ITEM#11 PER F.H. FLM#G749 7/18/97 J.A.

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) COLLINS TALLEY, JR.				2. Date of Death Month July Day 8 Year 1997		3. Time of Death 11:10 AM	
4a. Facility Name (If not institution, give street and number) MERCY HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
5. Social Security Number 216-20-7040		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 10/08/1929	
9. Birthplace (State or Foreign Country) Maryland							
Usual Residence of Decedent							
10a. State MD	10b. County N/A	10c. City, Town or Location BALTIMORE				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 653 CHARRAWAY ROAD			10f. Zip Code 21229		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager		16b. Kind of Business/Industry Transportation			
17. Father's Name (First, Middle, Last) Collins Talley, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Eunice Means			
19a. Informant's Name/Relationship (Type, Print) Shirley Muldrow				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 653 Charraway Road, Baltimore, MD 21229			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park		Data 7/15		20c. Location - City or Town, State Randallstown, MD	
21. Signature of Funeral Service Licensee <i>Leroy O. Dyett</i>		22. Name and Address of Facility LEROY O. DYETT & SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE., BALTO. 21207					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPTICEMIA Due to (or as a consequence of): INFECTED GANGRENOUS TOES Due to (or as a consequence of): PERIPHERAL ARTERIAL INSUFFICIENCY ONE YEAR							Approximate Interval Between Onset and Death 2 DAYS 5 WEEKS
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CARCINOMA OF THE LUNG RADIATION ESOPHAGITIS							23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) STELLA MARIS HOSPICE AT MERCY					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>Joseph D. Notarangelo M.D.</i>				29c. License number D07316		29d. Date signed (Month, Day, Year) 7-8-1997	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 ST. PAUL PLACE BALTIMORE 21202 JOSEPH D. NOTARANGELO M.D.							
31. Date filed (Month, Day, Year) JUL 15 1997				32. Registrar's Signature <i>John Davidson</i>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

JH

State
Registrar

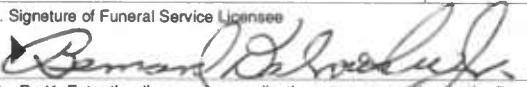
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21418

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Consetta vines				2. Date of Death Month 7 Day 13 Year 1997		3. Time of Death 11:39 am	
	4a. Facility Name (If not institution, give street and number) University of Maryland Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death Balt. City	
Funeral Director	5. Social Security Number 218-21-1722		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 18 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 10/31/1978	9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore City		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 216 N. Rose St.				10f. Zip Code 21224		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Unk.		College (1-4 or 5+) Unk.		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A		16b. Kind of Business/Industry N/A	
	17. Father's Name (First, Middle, Last) R. B. Johnson				18. Mother's Name (First, Middle, Maiden Surname) Carolyn Koethe			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Carolyn Koethe/Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 216 N. Rose St. Baltimore, MD 21224			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Crest Lawn Cemetery		Date 7/16/97		20c. Location - City or Town, State Howard Co., MD	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility B. Dabrowski & Son Funeral Home 2818 E. Baltimore St. Baltimore, MD 21224			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
	<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>a. Fulminant Hepatic Failure Due to (or as a consequence of):</p> <p>b. Hepatitis B infection Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____ Due to (or as a consequence of):</p> </div> <div style="width: 35%;"> <p>Approximate Interval Between Onset and Death</p> <p>1 month</p> <p>1 month</p> </div> </div>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Substance Abuse						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred		
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier  Resident Physician				29c. License number P09754		29d. Date signed (Month, Day, Year) 7/13/97		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Joseph Savitt								
State Registrar		31. Date filed (Month, Day, Year) JUL 15 1997		32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 21419**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) <i>Martha White</i>		2. Date of Death Month <i>7</i> Day <i>17</i> Year <i>1997</i>		3. Time of Death <i>10:35pm</i>	
4a. Facility Name (If not institution, give street and number) <i>North Charles Nursing Home</i>			4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>NA</i>
5. Social Security Number <i>248-18-0963</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>78</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>11-22-18</i>
9. Birthplace (State or Foreign Country) <i>SC</i>					
Usual Residence of Decedent					
10a. State <i>Md</i>	10b. County <i>NA</i>	10c. City, Town or Location <i>Baltimore</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <i>Apt. 202 1300 East Lanvale Street</i>			10f. Zip Code <i>21213</i>		10g. Citizen of What Country? <i>U.S.A</i>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10th Grade</i> College (1-4 or 5+) <i>NA</i>			
16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Domestic</i>		16b. Kind of Business/Industry <i>other people homes</i>			
17. Father's Name (First, Middle, Last) <i>Charlie M. Garrett</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Lillie McBrayer</i>		
19a. Informant's Name/Relationship (Type, Print) <i>James Watts</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>21212 833 Lenton Avenue Baltimore, Maryland</i>		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Greenmount Cemetery</i>		20c. Location - City or Town, State <i>07-16-97 Baltimore, Md.</i>	
21. Signature of Funeral Service Licensee <i>John R. March</i>		22. Name and Address of Facility <i>March F.H. East 1101 E. North Avenue Baltimore, Md</i>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>metastatic cancer of the throat.</i> Due to (or as a consequence of): b. <i>malignant pleural effusion.</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>A. Mathew M.D.</i>		29c. License number <i>D27716</i>		29d. Date signed (Month, Day, Year) <i>7-14-97</i>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>Aleyamma Mathew 5411 Old Frederick Rd. Baltimore, MD 21229.</i>					
31. Date filed (Month, Day, Year) <i>JUL 15 1997</i>		32. Registrar's Signature <i>John R. March</i>			

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at office.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: The law requires that the death certificate be executed and completely filled in by the funeral director.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21420

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANN WESLOCK		2. Date of Death Month July Day 11 Year 1997		3. Time of Death 12:10 am
	4a. Facility Name (If not institution, give street and number) 43 WINDWHISPER LANE		4b. City, Town, or Location of Death ANNAPOLIS		4c. County of Death ANNE ARUNDEL
Funeral Director	5. Social Security Number 213-38-7088	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) SEPT. 10, 1909		9. Birthplace (State or Foreign Country) RUSSIA		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State MD	10b. County N/A	10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 111 HAMLET HILL ROAD #601		10f. Zip Code 21210		10g. Citizen of What Country? U.S.A.
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) HOUSEWIFE		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) OWN HOME
	17. Father's Name (First, Middle, Last) SAMUEL PRESSMAN		18. Mother's Name (First, Middle, Maiden Surname) TOBY UNKNOWN		19. Informant's Name/Relationship (Type, Print) LAWRENCE F. WESLOCK / SON
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HAR ZION TIFERETH ISRAEL		20c. Location - City or Town, State 7/11/97 BALTIMORE, MD
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 Reisterstown Rd Pikesville, MD 21208		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Pulmonary edema Due to (or as a consequence of): b. Ischemic heart disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 2 days				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day Year)					
28b. Time of Injury M					
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No					
28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier Barbara L. Bean MD					
29c. License number D39497					
29d. Date signed (Month, Day, Year) July 11th 1997					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bean Barbara L. Suite 300 900, Bustgate Road, Annapolis Md 21401					
31. Date filed (Month, Day, Year) JUL 15 1997					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21421

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Marguerite Annetta Weaver

2. Date of Death

Month Day Year

July 14 1997

3. Time of Death

5:36am

4a. Facility Name (If not institution, give street and number)

Stella Maris

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

212-40-0152

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

May 15, 1910

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Timonium

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14 Rose St.

10f. Zip Code

21093

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

President

16b. Kind of Business/Industry

Weaver Stone Co.

17. Father's Name (First, Middle, Last)

Charles Gill

18. Mother's Name (First, Middle, Maiden Surname)

Alberta Hook

19a. Informant's Name/Relationship (Type, Print)

Joyce W. Clifton - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14 Rose St. Timonium, Md. 21093

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metro Crematory July 15, 1997

Date

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

J. [Signature]

22. Name and Address of Facility

Eckhardt Funeral Chapel
11605 Reisterstown Rd. Owings Mills, Md. 21117

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Pneumonia

Due to (or as a consequence of):

b. Congestive Heart Failure

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

[Signature]

29c. License number

D15504

29d. Date signed (Month, Day, Year)

7 14 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eddie Nakhuda, M.D. 2300 Dulaney Valley Rd Timonium, Md 21093

31. Date filed (Month, Day, Year)

JUL 15 1997

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

97 21422

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY LOUISE WALTERMEYER				2. DATE OF DEATH MONTH DAY YEAR JULY -13- 1997		3. TIME OF DEATH 9:40 P M	
4. SOCIAL SECURITY NUMBER 213-26-0976		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 8, 1929	
9a. FACILITY NAME (If not institution, give street and number) Carroll Co. Gen. Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Westminster		9c. COUNTY OF DEATH Carroll	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Carroll		10c. CITY, TOWN OR LOCATION Hampstead		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 2140 Harvey Gummel Rd.				10f. ZIP CODE 21074		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary		16b. KIND OF BUSINESS/INDUSTRY Spring Grove			
17. FATHER'S NAME (First, Middle, Last) J. Herbert Morsberger				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Cusack			
19a. INFORMANT'S NAME (Type/Print) William D. Talbott				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2294 Albert Rill Rd. Hampstead, Md. 21074			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) New Cathedral Cem. July 16, 1997 Baltimore, Md.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE J. Herbert Eckhardt				22. NAME AND ADDRESS OF FACILITY Eckhardt Funeral Chapel 3296 Charmil Dr. Manchester, Md. 21102			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → LUNG CANCER							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. LEFT PLEURAL EFFUSION							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Lamprey-Mills MD				29c. LICENSE NUMBER D44462		29d. DATE SIGNED (Month, Day, Year) 07/13/97	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) NIL LANTE LAMPREY-MILLS, CARROLL COUNTY GENERAL HOSP.							
31. DATE FILED (Month, Day, Year) JUL 15 1997				32. REGISTRAR'S SIGNATURE Johia Davidson-Rendall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

529



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21424

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOAN WARD				2. Date of Death Month 07 Day 12 Year 1997				3. Time of Death 1430										
	4a. Facility Name (If not institution, give street and number) ST AGNES HOSPITAL				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death N/A										
Funeral Director	5. Social Security Number 074-22-3333		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 68 Yrs.		8. Date of Birth (Month, Day, Year) NOV 27 1928		9. Birthplace (State or Foreign Country) NEW YORK										
	Usual Residence of Decedent																		
To Be Completed by Funeral Director	10a. State MD		10b. County BALTIMORE		10c. City, Town or Location CATONSVILLE				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
	10e. Street and Number 6008 BURNT OAK ROAD				10f. Zip Code 21228		10g. Citizen of What Country? USA												
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE											
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER				16b. Kind of Business/Industry OWN HOME										
	17. Father's Name (First, Middle, Last) WILLIAM ROONEY				18. Mother's Name (First, Middle, Maiden Surname) ELIZABETH COONEY														
	19a. Informant's Name/Relationship (Type, Print) CALEB H. WARD, SR., HUSBAND				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6008 BURNT OAK ROAD, CATONSVILLE, MD 21228														
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GATE OF HEAVEN		20c. Date 7/16		20d. Location - City or Town, State HAWTHORNE, NY												
	21. Signature of Funeral Service Licensee <i>Philip Stahl</i>				22. Name and Address of Facility STERLING ASHTON FUNERAL HOME, INC. 736 EDMONDSON AVE., BALTIMORE, MD 21228														
	23a. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																		
	<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>e. hypoxemia</td> <td rowspan="4"> Due to (or as a consequence of): b. cor pulmonale c. pulmonary fibrosis d. scleroderma </td> <td>hours</td> </tr> <tr> <td></td> <td>years</td> </tr> <tr> <td></td> <td>years</td> </tr> <tr> <td></td> <td>years</td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e. hypoxemia	Due to (or as a consequence of): b. cor pulmonale c. pulmonary fibrosis d. scleroderma	hours		years		years	
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e. hypoxemia	Due to (or as a consequence of): b. cor pulmonale c. pulmonary fibrosis d. scleroderma	hours																
			years																
			years																
			years																
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																			
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown																			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																			
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																			
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred											
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)													
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																			
29b. Signature and title of certifier <i>Joanne Saunders MD</i>				29c. License number P 33061		29d. Date signed (Month, Day, Year) July 12, 1997													
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Joanne Saunders 900 Caton Avenue Baltimore 21228																			
31. Date filed (Month, Day, Year) JUL 15 1997																			
32. Registrar's Signature <i>John Davidson-Randall</i>																			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

WRC
97-3699-510
BASIL
WAGNER JR.

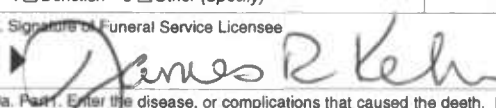
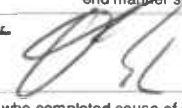
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 21425

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Basil Wagner, Jr.				2. Date of Death Month JULY Day 04 , Year 1997		3. Time of Death 3:50 PM.			
	4a. Facility Name (If not institution, give street and number) 5422 YORK RD.				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death NA			
Funeral Director	5. Social Security Number 219-18-8768		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 8, 1919	9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent									
10a. State MD		10b. County NA		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 5610 York Rd.				10f. Zip Code 21212		10g. Citizen of What Country? USA				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Musician		16b. Kind of Business/Industry Music				
17. Father's Name (First, Middle, Last) Basil Wagner				18. Mother's Name (First, Middle, Maiden Surname) Carrie Pattison Webb						
19a. Informant's Name/Relationship (Type, Print) Charles Webb Wagner/ Brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24 Indian Lane, Baltimore, MD 21210						
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematory 7-12		Date Baltimore, MD		20c. Location - City or Town, State				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Henry W. Jenkins & Sons 4905 York Rd., Baltimore, MD 21212						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Atherosclerosis Cardiovascular disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) AT SCENE								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JULY 05, 1997				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) David R. Fowler 111 Penn Street, Baltimore, Maryland 21201										
31. Date filed (Month, Day, Year) JUL 15 1997										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 21426**
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Pearl E. Wiles				2. Date of Death Month July Day 14 Year 1997		3. Time of Death 3:30 am									
	4a. Facility Name (If not institution, give street and number) 1615 Four George Court				4b. City, Town, or Location of Death Dundalk		4c. County of Death Baltimore Co.									
Funeral Director	5. Social Security Number 218-36-4227		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 54 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept 16, 1942	9. Birthplace (State or Foreign Country) Maryland								
	Usual Residence of Decedent															
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore Co.		10c. City, Town or Location Dundalk		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
	10e. Street and Number 1615 Four George Court				10f. Zip Code 21222		10g. Citizen of What Country? U.S.A									
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White									
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurses Aide		16b. Kind of Business/Industry Ivy Hall Nursing Home											
	17. Father's Name (First, Middle, Last) George K. Burris				18. Mother's Name (First, Middle, Maiden Surname) Marthe Martin											
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) John E. Wiles (Husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1615 Four George Court, Dundalk, Md 21222											
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Cemetery		Date 7/17/97		20c. Location - City or Town, State Baltimore, Maryland									
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility A. Alan Seitz, Jr. Funeral Home 3818 Roland Avenue, Baltimore, Maryland 21211											
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Cachexia</td> <td>Approximate Interval Between Onset and Death 1 year</td> </tr> <tr> <td>b. Atherosclerosis (Ischemic Bowel)</td> <td>1 year</td> </tr> <tr> <td>c. Diabetes Mellitus</td> <td>>20 years</td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. Cachexia	Approximate Interval Between Onset and Death 1 year	b. Atherosclerosis (Ischemic Bowel)	1 year	c. Diabetes Mellitus	>20 years	d.
Immediate Cause (Final disease or condition resulting in death)	a. Cachexia	Approximate Interval Between Onset and Death 1 year														
	b. Atherosclerosis (Ischemic Bowel)	1 year														
	c. Diabetes Mellitus	>20 years														
	d.															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atherosclerotic Coronary Artery Disease Chronic Renal Failure - Dialysis Dependent						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)														
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D 22848		29d. Date signed (Month, Day, Year) 7/14/97										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) White Square Dialysis Ctr; 6830 Hospital Drive; Baltimore MD 21237																
31. Date filed (Month, Day, Year) JUL 15 1997		32. Registrar's Signature 														

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

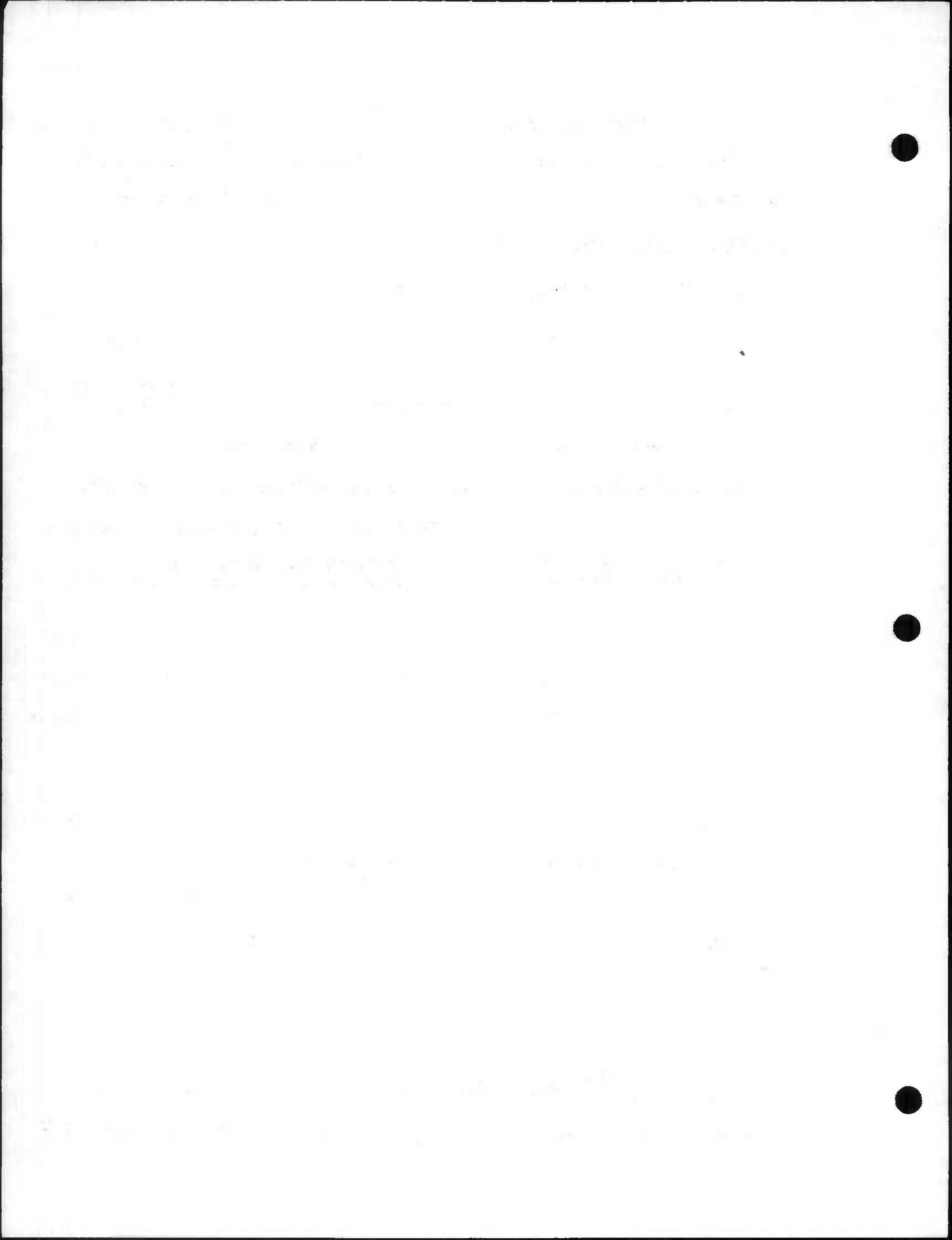
Division of Vital Records, P.O. Box 68760,

To the Hospital for Attending Physician: The law requires that the death certificate be executed within 48 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21427

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary A. Whitehead				2. Date of Death Month July Day 10 Year 1997				3. Time of Death 10 AM	
	4e. Facility Name (If not institution, give street and number) 111 Taunton Avenue				4b. City, Town, or Location of Death Catonsville				4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 215-12-5340		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Year) May 27 1922	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Baltimore		10c. City, Town or Location Catonsville		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
Usual Residence of Decedent										
10e. Street and Number 111 Taunton Avenue				10f. Zip Code 21228				10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary				16b. Kind of Business/Industry Insurance Company		
17. Father's Name (First, Middle, Last) Arthur Aston						18. Mother's Name (First, Middle, Maiden Surname) Bertha Hutchinson				
19a. Informant's Name/Relationship (Type, Print) Ann W. Kraus/Daughter						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3216-A Normandy Woods Dr. Ellicott City, MD 21043				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Lorraine Park Cemetery 7/14/97				20c. Location - City or Town, State Baltimore, MD		
21. Signature of Funeral Service Licensee Dawn F. McDonald				22. Name and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Rd. Baltimore, MD 21228						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
Immediate Cause (Final disease or condition resulting in death) e. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of):										
Approximate Interval Between Onset and Death YEARS										
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
b. Due to (or as a consequence of):										
c. Due to (or as a consequence of):										
d. Due to (or as a consequence of):										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
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26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier G. Williams M.D.				29c. License number D11171				29d. Date signed (Month, Day, Year) July 10, 1997		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E-P. Williams & Sons 405 Frederick Ave Catonsville, Md.										
31. Date filed (Month, Day, Year) JUL 15 1997				32. Registrar's Signature John Davidson-Randall 21228						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21428

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Vincent WELSH				2. Date of Death Month July Day 2 Year 1997		3. Time of Death 8:16 P.M.	
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center				4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 218-24-8528	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) March 10, 1930	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Baltimore	10c. City, Town or Location Baltimore County			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 9921 Richlyn Drive			10f. Zip Code 21128		10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Supervisor		16b. Kind of Business/Industry Manufacturing			
	17. Father's Name (First, Middle, Last) W Carl Vernon Welsh				18. Mother's Name (First, Middle, Maiden Surname) Thelma Lucinda Matthews			
	19a. Informant's Name/Relationship (Type, Print) Lois Welsh/wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9921 Richlyn Drive, Perry Hall, Maryland 21128				
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State	
	21. Signature of Funeral Service Licensee  Ronald S. Wade, Director		22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): b. Colon cancer with extensive mets Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							2 weeks 3 years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute tubular necrosis						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  Dr. Kristen Pena MD		29c. License number R D 2323		29d. Date signed (Month, Day, Year) 7-2-97		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Kristen Pena 9000 Franklin Square Dr. Baltimore, Maryland 21237								
31. Date filed (Month, Day, Year) JUL 15 1997		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21429

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Alma E. Anderson					2. Date of Death Month Day Year June 28, 1997		3. Time of Death 6:20 PM		
	4e. Facility Name (If not institution, give street and number) 428 Northwest Drive					4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 579-16-0274		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) Sep. 7, 1920		9. Birthplace (State or Foreign Country) Washington, D.C.	
	Usual Residence of Decedent					10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Rockville
To Be Completed by Funeral Director	10e. Street and Number 5 Pebble Ridge Court		10f. Zip Code 20854		10g. Citizen of What Country? U.S.A.		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Personnel Administrator		16b. Kind of Business/Industry PEPCO					
	17. Father's Name (First, Middle, Last) Paul S. Hanson					18. Mother's Name (First, Middle, Maiden Surname) Annadelle E. Link				
	19a. Informant's Name/Relationship (Type, Print) Martha Christine Anderson					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Pebble Ridge Court Rockville, Maryland 20854				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		Date 7/2/97		20c. Location - City or Town, State Suitland, Maryland			
	21. Signature of Funeral Service Licensee <i>John L. Chigale</i>					22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901				
	23a. Permit. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Aspiration pneumonia</i> Due to (or as a consequence of): b. <i>Dementia, chronic</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					Approximate Interval Between Onset and Death Days Years				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Lymphocytic Leukemia</i> <i>Deep venous thrombosis</i>					23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Robert Musselmann MD</i>		29c. License number D 47215		29d. Date signed (Month, Day, Year) 6/30/97				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10801 Lockwood Dr. # 200 (Robert Musselmann, MD) Silver Spring, MD 20901										
31. Date filed (Month, Day, Year) JUL 01 1997					Register's Signature <i>John A. Davidson-Randall</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

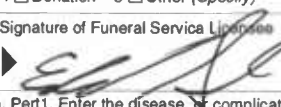

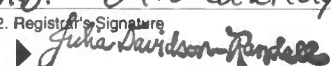
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21430

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Estelle Akst				2. Date of Death Month June Day 30 Year 1997				3. Time of Death 6:40PM					
	4a. Facility Name (If not institution, give street and number) Suburban Hospital				4b. City, Town, or Location of Death Bethesda				4c. County of Death Montgomery					
Funeral Director	5. Social Security Number 074-40-8602		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) May 18, 1910		9. Birthplace (State or Foreign Country) Russia	
	Usual Residence of Decedent													
To Be Completed by Funeral Director	10a. State Md.		10b. County Montgomery		10c. City, Town or Location Rockville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
	10e. Street and Number 1801 E. Jefferson St.				10f. Zip Code 20852				10g. Citizen of What Country? US					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home					
	17. Father's Name (First, Middle, Last) Morris Wexler				18. Mother's Name (First, Middle, Maiden Surname) Freida Krentzle									
	19a. Informant's Name/Relationship (Type, Print) George Akst/ Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8211 Woodland Ave. Annandale, Va. 22003									
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) King David Memorial Gardens 7/2/97 Falls Church, Va.				20c. Location - City or Town, State					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Edward Sagel Funeral Direction 1091 Rockville Pike Rockville, Md. 20852									
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Bowel perforation Due to (or as a consequence of): b. Bowel obstruction Due to (or as a consequence of): c. Cardiomyopathy Due to (or as a consequence of): d. Metastatic adenocarcinoma													
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown													
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No														
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No														
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No														
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)														
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined														
28a. Date of Injury (Month, Day Year)				28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred						
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.														
29b. Signature and title of certifier  Harry Bigham MD				29c. License number MDP 38888				29d. Date signed (Month, Day, Year) 7/1/97						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harry Bigham MD. 6410 Rockledge Drive Bethesda MD 20817														
31. Date filed (Month, Day, Year) JUL 03 1997				32. Registrar's Signature  John Davidson-Randall										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21431

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Shirley T. Austin

2. Date of Death

June 26, 1997

3. Time of Death

9:30 A. M.

4e. Facility Name (If not institution, give street and number)

1102 Hunters Mill Avenue

4b. City, Town, or Location of Death

Fort Washington

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

003--14-5147

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 2, 1926

9. Birthplace (State or Foreign Country)

New Hampshire

Usual Residence of Decedent

10a. State

Maryland Prince George's

10b. County

10c. City, Town or Location

Fort Washington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1102 Hunters Mill Avenue

10f. Zip Code

20744

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Dry Cleaning

17. Father's Name (First, Middle, Last)

Frederick B. Taylor

18. Mother's Name (First, Middle, Maiden Surname)

Helen Langford

19e. Informant's Name/Relationship (Type, Print)

Pamela L. Beverly/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2206 Browns Lane, Ft. Washington, Md. 20744

20e. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metropolitan Crematory

Date

6/27/97

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

George P. Kalas Funeral Home
6160 Oxon Hill Rd. Oxon Hill, Md. 2074523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. *Chronic renal failure*
Due to (or as a consequence of):b. *Congestive heart failure*
Due to (or as a consequence of):c.
Due to (or as a consequence of):d.
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined28e. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29e. Certifier
(Check only
one)29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D30296

29d. Date signed (Month, Day, Year)

6-26-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DEBORAH M. THOMPSON MD 5100 Auth Way Suitland MD

31. Date filed (Month, Day, Year)

JUN 30 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerDivision of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21432

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dianne Elizabeth Ashford

2. Date of Death

Month
June

Day

30

Year

1997

3. Time of Death

2:PM

4a. Facility Name (If not institution, give street and number)

603 Sligo Avenue Apt # 311

4b. City, Town, or Location of Death

Silver Spring Montgomery

4c. County of Death

Wash, DC

5. Social Security Number

579-58-5017

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

51

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
June 30 1946

9. Birthplace (State or Foreign Country)

Wash, DC

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

603 Sligo Avenue

10f. Zip Code

20910

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Social Worker

16b. Kind of Business/Industry

Dept Of Human

Services

17. Father's Name (First, Middle, Last)

Chester Ambrose Cooke

18. Mother's Name (First, Middle, Maiden Surname)

Beatrice Scott Cooke

19a. Informant's Name/Relationship (Type, Print)

Eric Ashford (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

927 Clopper Rd T-1 Gaithersburg, MD 20878

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial

Date

7/7/97

20c. Location - City or Town, State

Landover, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Latney's Funeral Home, Inc.

3831 Georgia Ave, NW Wash, DC 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

15 minutes

b. Hypertension

Due to (or as a consequence of):

Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D08546

29d. Date signed (Month, Day, Year)

June 30, 1997

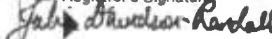
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

John Tauber 8218 Wisconsin Ave, Bethesda, Maryland

31. Date filed (Month, Day, Year)

JUL 14 1997

Registrar's Signature



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21433

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) JOCHEN R. BERGT				2. Date of Death Month JUNE Day 16 Year 1997		3. Time of Death 04:30 PM FOUND	
4a. Facility Name (If not institution, give street and number) 13525 BRANDYWINE ROAD				4b. City, Town, or Location of Death BRANDYWINE		4c. County of Death PRINCE GEORGES	
5. Social Security Number 574 18 9264		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 59 Yrs.		8. Date of Birth (Month, Day, Year) Feb 10, 1938	
9. Birthplace (State or Foreign Country) Germany		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Brandywine	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 13525 Brandywine Road		10f. Zip Code 20613		10g. Citizen of What Country? United States	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Andrews Golf Course		16b. Kind of Business/Industry Chef	
17. Father's Name (First, Middle, Last) Atto Bergt				18. Mother's Name (First, Middle, Maiden Surname) Heartha (UNKNOWN)			
19a. Informant's Name/Relationship (Type, Print) Walter Dorsey				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13525 Brandywine Road, Brandywine, MD 20613			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lee Crematory		Date June 17, 1997		20c. Location - City or Town, State Clinton, Maryland	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Rd, Clinton, MD 20735			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier  DME		29c. License number D 339154		29d. Date signed (Month, Day, Year) JULY 2, 1997			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARIO F. GOLVE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785							
31. Date filed (Month, Day, Year) JUL 03 1997		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

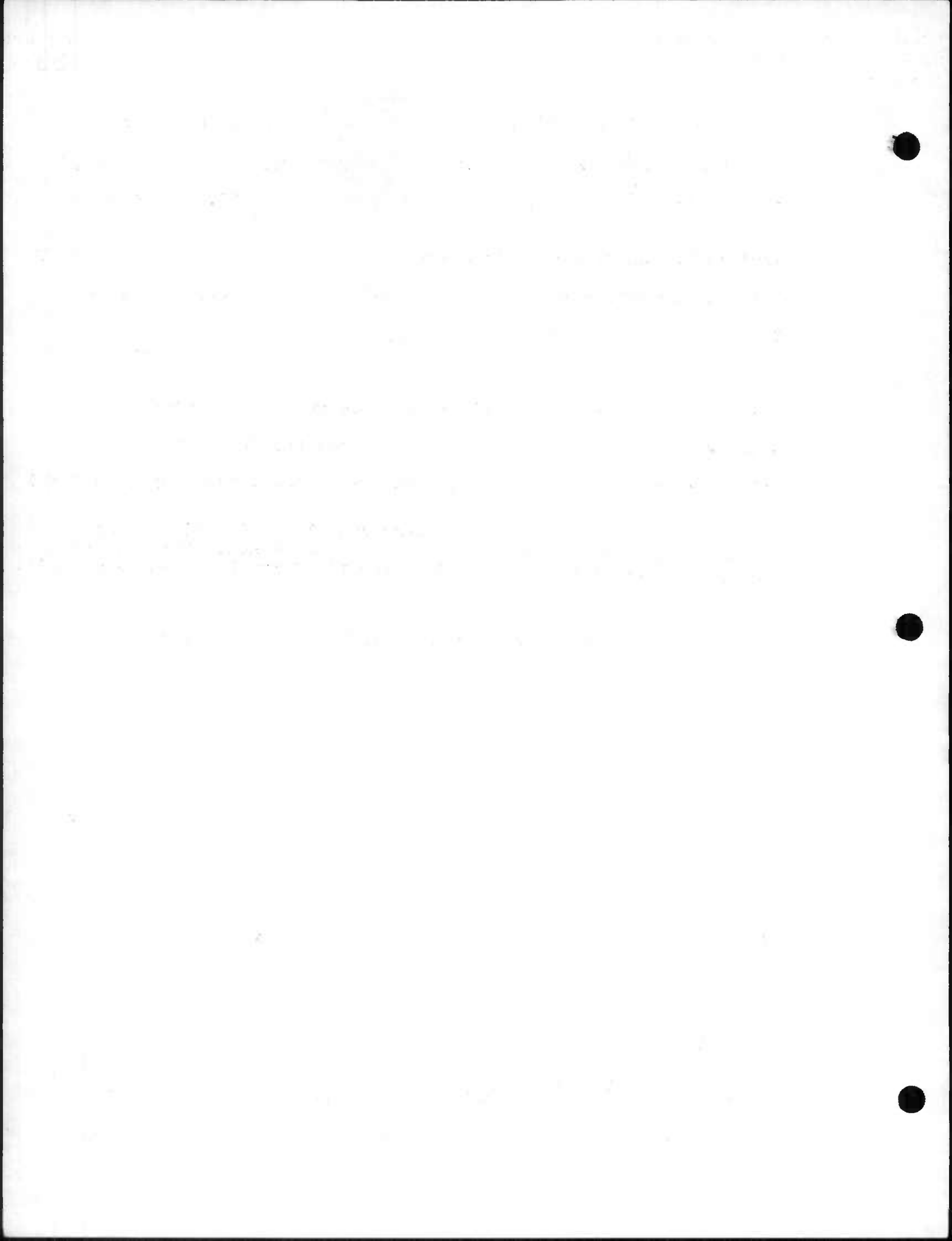
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21434

Certificate of Death

Reg. No.

Item:5 per FH G-750 8/19/97 dh

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) THOMAS BYRNE BAKER				2. Date of Death Month June Day 30 Year 1997		3. Time of Death 3:15 PM	
	4a. Facility Name (If not institution, give street and number) 440 Doris Circle				4b. City, Town, or Location of Death Aberdeen		4c. County of Death Harford	
Funeral Director	5. Social Security Number 235-46-2203		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 11, 1929	
	9. Birthplace (State or Foreign Country) W. Virginia							
To Be Completed by Funeral Director	Usual Residence of Decedent							
	10a. State Maryland		10b. County Harford		10c. City, Town or Location Aberdeen			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 440 Doris Circle				10f. Zip Code 21001		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1953-61		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5 +		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Education Specialist		16b. Kind of Business/Industry U.S. Government			
17. Father's Name (First, Middle, Last) Royal Frank Baker				18. Mother's Name (First, Middle, Maiden Surname) Verna Evelyn Nugen				
19a. Informant's Name/Relationship (Type, Print) Elsie M. Baker - Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 440 Doris Circle, Aberdeen, Md. 21001				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) R.A. Ferris & Company		Date 7-2-97		20c. Location - City or Town, State W. Chester, Pa.		
21. Signature of Funeral Service Licensee <i>Holly K. McComas</i>				22. Name and Address of Facility Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e. DEHYDRATION Due to (or as a consequence of):								3 WEEKS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. METASTATIC GASTRIC CARCINOMA Due to (or as a consequence of):								2 1/2 MONTHS
c. _____ Due to (or as a consequence of):								
d. _____ Due to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>John G. Samello MD</i>				29c. License number 044390		29d. Date signed (Month, Day, Year) 07/01/97		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) IVAN BORRELLO JOHNS HOPKINS ONCOLOGY CENTER 600 N. WOLFE ST								
31. Date filed (Month, Day, Year) JUL 1 1997								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

DHMM 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21435

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANNA VIRGINIA BECKMAN				2. Date of Death Month Day Year JUNE 28, 1997		3. Time of Death 6:30 AM	
	4a. Facility Name (If not institution, give street and number) KEISER PERSONAL CARE HOME				4b. City, Town, or Location of Death OAKLAND		4c. County of Death GARRETT	
Funeral Director	5. Social Security Number 234-70-1637		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		8. Date of Birth (Month, Day, Year) JUNE 15, 1907	
	9. Birthplace (State or Foreign Country) WEST VIRGINIA							
To Be Completed by Funeral Director	Usual Residence of Decedent							
	10a. State MD		10b. County GARRETT		10c. City, Town or Location DEER PARK		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 1065 FRICKS CROSSING ROAD				10f. Zip Code 21550		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry OWN HOME			
	17. Father's Name (First, Middle, Last) HERVEY FRANCIS EVANS				18. Mother's Name (First, Middle, Maiden Surname) CARRIE WINTERS			
	19a. Informant's Name/Relationship (Type, Print) CYNTHIA SIMPSON - GRANDDAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1065 FRICKS CROSSING ROAD DEER PARK, MD 21550			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) EGLON CEMETERY		20c. Date 6/30/97		20d. Location - City or Town, State EGLON, WV	
	21. Signature of Funeral Service Licensee  MO0167				22. Name and Address of Facility P.O. BOX 243 DURST FUNERAL HOME - OAKLAND, MD 21550			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. myocardial infarction Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death hours							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Asthma, Hypertension, Atrial Fibrillation, dementia						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Personal Care Home						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29e. Certifier (Check only one) 29f. Signature and title of certifier  29g. License number D26650 29h. Date signed (Month, Day, Year) 06/30/97								
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Margaret A. Kaiser MD PO Box 486 Oakland MD 21550								
31. Date filed (Month, Day, Year) JUL 1 1997				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97 21436

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROY RAYMOND BOHR					2. Date of Death Month Day Year June 27, 1997			3. Time of Death 19:35pm				
	4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL					4b. City, Town, or Location of Death ROCKVILLE			4c. County of Death MONTGOMERY				
Funeral Director	5. Social Security Number 217-03-2585		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Year) April 7, 1919				
									9. Birthplace (State or Foreign Country) Maryland				
Usual Residence of Decedent													
10a. State Md.		10b. County Montgomery		10c. City, Town or Location Gaithersburg				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 507A South Frederick Ave #5					10f. Zip Code 20877			10g. Citizen of What Country? United States					
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1941- If Yes, Give Year or Dates: 1942		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Painter			16b. Kind of Business/Industry Residential					
17. Father's Name (First, Middle, Last) James Bohr					18. Mother's Name (First, Middle, Maiden Surname) Pearl Jones								
19a. Informant's Name/Relationship (Type, Print) Virginia Bohr					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 507A S. Frederick Ave. #5 Gaithersburg, Md. 20877								
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cem.			Date July 3, 1997		20c. Location - City or Town, State Arlington, Va.					
21. Signature of Funeral Service Licensee <i>Curtis E. Day</i>					22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, Md. 20877								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
<table border="0" style="width:100%;"> <tr> <td style="width:30%;">Immediate Cause (Final disease or condition resulting in death)</td> <td style="width:50%;"> a. Hypoxia Due to (or as a consequence of): b. Respiratory Failure Due to (or as a consequence of): c. Emphysema Due to (or as a consequence of): d. Nicotine Abuse </td> <td style="width:20%;"> Approximate Interval Between Onset and Death 2 Days 2 Years Many Years </td> </tr> </table>											Immediate Cause (Final disease or condition resulting in death)	a. Hypoxia Due to (or as a consequence of): b. Respiratory Failure Due to (or as a consequence of): c. Emphysema Due to (or as a consequence of): d. Nicotine Abuse	Approximate Interval Between Onset and Death 2 Days 2 Years Many Years
Immediate Cause (Final disease or condition resulting in death)	a. Hypoxia Due to (or as a consequence of): b. Respiratory Failure Due to (or as a consequence of): c. Emphysema Due to (or as a consequence of): d. Nicotine Abuse	Approximate Interval Between Onset and Death 2 Days 2 Years Many Years											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <table border="0" style="width:100%;"> <tr> <td style="width:60%;"> Pneumonia Weight Loss Alcohol Abuse </td> <td style="width:40%;"> 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No </td> </tr> </table>											Pneumonia Weight Loss Alcohol Abuse	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Pneumonia Weight Loss Alcohol Abuse	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)													
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. Signature and title of certifier <i>Rashid Baghai Naini</i>					29c. License number D39372		29d. Date signed (Month, Day, Year) June, 27 1997						
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) RASHAID BAGHAI NAINI 344 University Blvd. West Silver Spring, Md. 20901													
31. Date filed (Month, Day, Year) JUL 03 1997					32. Registrar's Signature <i>Juan Davidson-Rendell</i>								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21437

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EUGENE V. BORLAND			2. Date of Death Month Day Year JUNE 27, 1997		3. Time of Death 5:51 AM	
	4a. Facility Name (If not institution, give street and number) HOLY CROSS HOSPITAL			4b. City, Town, or Location of Death SILVER SPRING		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 578-26-2820		6. Sex 15 M 2 F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	8. Date of Birth (Month, Day, Year) FEB. 19, 1926	9. Birthplace (State or Foreign Country) WASH. D.C.
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State MD.	10b. County MONTGOMERY	10c. City, Town or Location SILVER SPRING			10d. Inside City Limits 1 X Yes 2 No	
	10e. Street and Number 808 PHILADELPHIA AVE.			10f. Zip Code 20910		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 N Ever Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DRAFTSMAN AND ILLUSTRATOR		16b. Kind of Business/Industry RESEARCH AND DESIGN		
	17. Father's Name (First, Middle, Last) WILLIAM JAMES BORLAND			18. Mother's Name (First, Middle, Maiden Surname) JANE CONOVER			
	19a. Informant's Name/Relationship (Type, Print) JULIA A. BORLAND/WIFE			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS ITEM #10			
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CHAMBERS CREMATORY		Date 6/29/97	20c. Location - City or Town, State RIVERDALE, MD.	
	21. Signature of Funeral Service Licensee W. H. Chambers		22. Name and Address of Facility SILVER SPRING, MD. CHAMBERS FUNERAL HOMES, P.A.		20910		
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory Failure Due to (or as a consequence of): b. Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 2 wks yrs						
	23b. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. Granulomatous colitis						
23c. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown							
24a. Was an autopsy performed? 1 Yes 2 X No							
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No							
25. Was case referred to medical examiner? 1 Yes 2 X No							
26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined							
28a. Date of Injury (Month, Day Year)							
28b. Time of Injury M							
28c. Injury at Work? 1 Yes 2 No							
28d. Describe how injury occurred							
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier Carroll D. Mahoney M.D.							
29c. License number PO 4775							
29d. Date signed (Month, Day, Year) 6-27-97							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARROLL D. MAHONEY M.D. 10301 GEORGIA AVE, SILVER SPRING, MD.							
31. Date filed (Month, Day, Year) JUN 30 1997							
32. Registrar John Davidson							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21438

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert E. Broadhurst						2. Date of Death Month June Day 29 Year 1997		3. Time of Death 8:15 AM	
	4a. Facility Name (If not institution, give street and number) 5806 Sonoma Road						4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 212-20-2278		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 30, 1925		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Montgomery		10c. City, Town or Location Bethesda				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 5806 Sonoma Road				10f. Zip Code 20817		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Construction Supervisor			16b. Kind of Business/Industry Carpentry		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Earl M. Broadhurst						18. Mother's Name (First, Middle, Maiden Surname) Helen M. Bosley			
	19a. Informant's Name/Relationship (Type, Print) Regina M. Broadhurst						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5806 Sonoma Road, Bethesda, MD 20817			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date 6/30/97		20c. Location - City or Town, State Alexandria, VA			
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Carcinoma of the lung with metastasis Due to (or as a consequence of): b. Chronic alcoholism Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death 2 years 30 years	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
Medical Certification: To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined							
	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
State Registrar	29b. Signature and title of certifier  MD				29c. License number D20065		29d. Date signed (Month, Day, Year) 6/30/97			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eva Morell M.D., 6000 Executive Blvd., #300 Rockville, MD 20852									
31. Date filed (Month, Day, Year) JUL 01 1997		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that every entry must be clearly documented and verified by the relevant parties. This ensures transparency and accountability in the financial process.

2. The second part of the document outlines the procedures for handling discrepancies. It states that any difference between the recorded amounts and the actual amounts must be investigated immediately. The responsible parties are required to provide a detailed explanation for the discrepancy and take corrective action to prevent future occurrences.

3. The third part of the document describes the process for reconciling accounts. It requires that all accounts be reconciled on a regular basis, typically at the end of each month. This involves comparing the internal records with the external statements from banks and other financial institutions to ensure they match.

4. The fourth part of the document discusses the importance of maintaining proper documentation. It states that all supporting documents, such as receipts, invoices, and contracts, must be kept in a secure and organized manner. This documentation is essential for auditing and for resolving any disputes that may arise.

5. The fifth part of the document outlines the responsibilities of the accounting department. It states that the department is responsible for ensuring that all financial data is accurately recorded and reported. It also emphasizes the need for the department to stay up-to-date with the latest accounting standards and regulations.

6. The sixth part of the document discusses the importance of communication. It states that the accounting department must maintain open lines of communication with other departments, such as sales and purchasing, to ensure that all financial transactions are properly recorded and processed.

7. The seventh part of the document outlines the process for handling payroll. It states that all payroll transactions must be processed accurately and on time. It also emphasizes the need for the accounting department to maintain accurate records of all payroll data, including employee salaries, benefits, and taxes.

8. The eighth part of the document discusses the importance of budgeting. It states that the accounting department must work closely with management to develop and maintain an accurate budget. This involves tracking actual expenses against the budgeted amounts and identifying any variances.

9. The ninth part of the document outlines the process for handling taxes. It states that the accounting department is responsible for ensuring that all taxes are calculated and paid correctly. It also emphasizes the need for the department to stay up-to-date with the latest tax laws and regulations.

10. The tenth part of the document discusses the importance of financial reporting. It states that the accounting department must prepare accurate and timely financial statements, including the balance sheet, income statement, and cash flow statement. These statements are essential for providing management and other stakeholders with a clear picture of the company's financial health.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21439

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Howard F. Brubach

2. Date of Death

Month Day Year
July 1, 1997

3. Time of Death

3:47AM

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

216-44-6765

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 10, 1907

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5700 Harwick Road

10f. Zip Code

20816

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Physical Biologist

16b. Kind of Business/Industry

National Institutes
of Health

17. Father's Name (First, Middle, Last)

Theodore Brubach

18. Mother's Name (First, Middle, Maiden Surname)

Mary Von Moss

19a. Informant's Name/Relationship (Type, Print)

Jean B. Baines / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6621 Grey Fox Drive, Springfield, Virginia 22152

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Cedar Hill Cemetery

Date

July 3, 1997

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

M00831

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.
7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

e. Respiratory insufficiency

Due to (or as a consequence of):

48 hours

b. Sepsis

Due to (or as a consequence of):

8 days

c. Acute septic arthritis

Due to (or as a consequence of):

8 days

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Asthma

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Donna Rinis, M.D. 6000 Executive Blvd., Suite 300, Rockville, Maryland 20852

31. Date filed (Month, Day, Year)

JUL 03 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21440

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Raisa

Buslovich

2. Date of Death

Month Day Year

JULY 01 1997

3. Time of Death

1030 AM

4a. Facility Name (If not institution, give street and number)

SUBURBAN HOSPITAL

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

220-23-2792

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

SEPT. 22, 1915

9. Birthplace (State or Foreign Country)

RUSSIA

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

KENSINGTON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10920 CONNECTICUT AV, # 209

10f. Zip Code

20895

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SURGEON

16b. Kind of Business/Industry

MEDICAL

17. Father's Name (First, Middle, Last)

YANKEL BUSLOVICH

18. Mother's Name (First, Middle, Maiden Surname)

BLUMA SHAPIRO

19a. Informant's Name/Relationship (Type, Print)

SIMON BUSLOVICH BROTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10920 CONNECTICUT AVE #519, KENSINGTON MD 20895

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

PARKLAWN CEMETERY

Date

7/3/97

20c. Location - City or Town, State

ROCKVILLE, MD

21. Signature of Funeral Service Licensee

Frank A. Stoeck

22. Name and Address of Facility

DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC
1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. NEUTROPENIC SEPSIS

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

24 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. REFRACTORY MULTIPLE MYELOMA

Due to (or as a consequence of):

4 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. Signature and title of certifier

Carolyn Hendricks MD

29d. License number

137236

29e. Date signed (Month, Day, Year)

JULY 01, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

CAROLYN HENDRICKS MD

SUITE 300 ROCKVILLE
9707 MEDICAL CENTER DRIVE MD 20850

31. Date filed (Month, Day, Year)

JUL 03 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

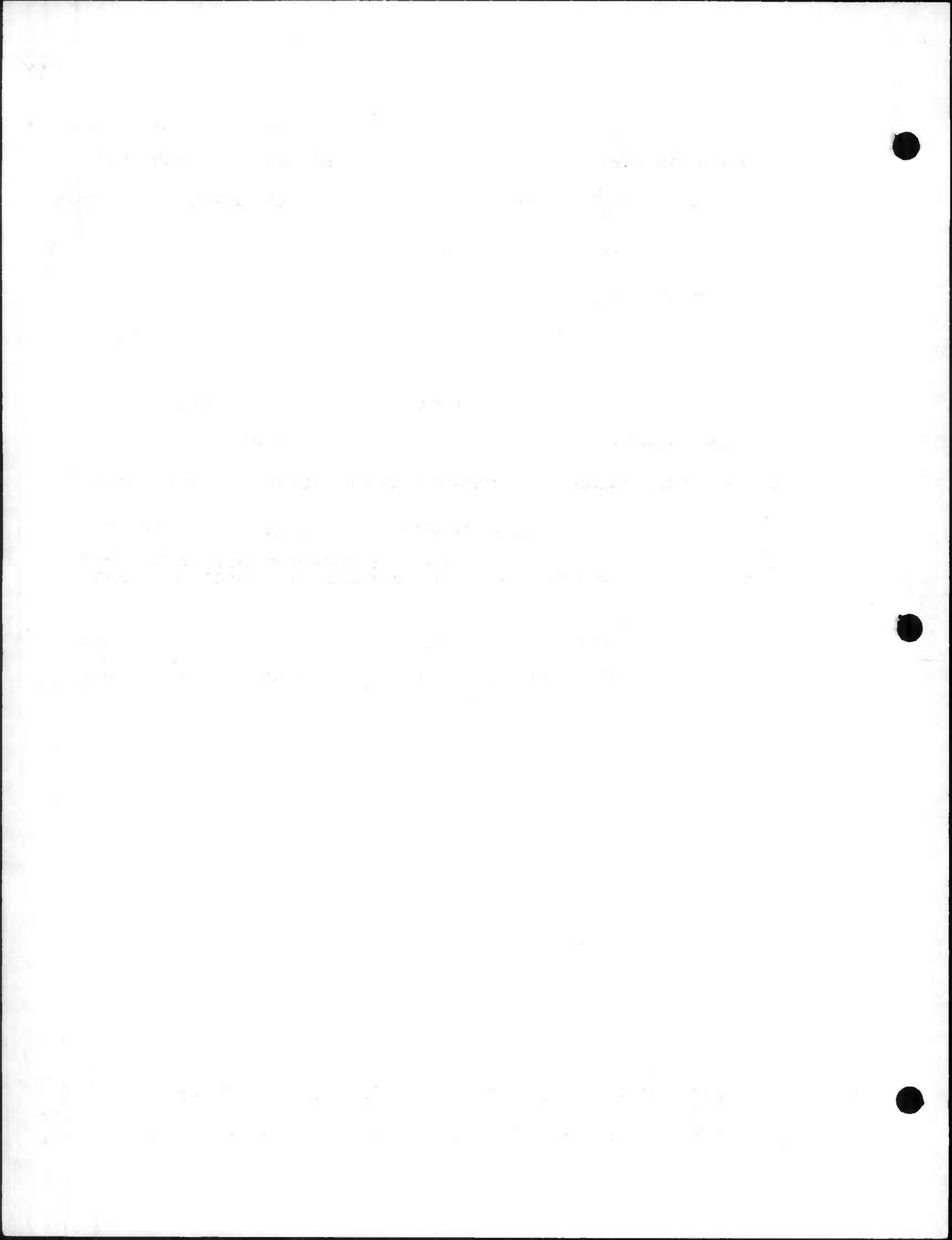
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21441

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) Frank Akos Biro				2. Date of Death Month Day Year June 16, 1997		3. Time of Death 12:15 AM	
4a. Facility Name (If not institution, give street and number) 13899 Foggy Bottom Court				4b. City, Town, or Location of Death Mount Airy		4c. County of Death Frederick	
5. Social Security Number 577-68-0816		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 57 Yrs.		8. Date of Birth (Month, Day, Year) April 3, 1940	
9. Birthplace (State or Foreign Country) Hungary		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Mount Airy	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 13899 Foggy Bottom Court		10f. Zip Code 21771		10g. Citizen of What Country? United States	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1955-1971		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineering Consultant		16b. Kind of Business/Industry Architecture			
17. Father's Name (First, Middle, Last) Major Karoly Biro				18. Mother's Name (First, Middle, Maiden Surname) Maria Schaff			
19a. Informant's Name/Relationship (Type, Print) Peter A. Gruenther				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 268, Clarksburg, MD 20871-0268			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		Date 6-20-97		20c. Location - City or Town, State Beltsville, Maryland	
21. Signature of Funeral Service Licensee Eileen H. Rapp				22. Name and Address of Facility Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus							
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier O. C. M. E.				29c. License number		29d. Date signed (Month, Day, Year) June 16, 1997	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laron Locke, M. D., 111 Penn Street, Baltimore, MD 21201							
31. Date filed (Month, Day, Year) JUL 03 1997				32. Registrar's Signature Julia Davidson-Rodell			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21442

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Edward Beckman

2. Date of Death

June 29, 1997

3. Time of Death

0620 A

Funeral
Director

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

011-10-5292

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 28, 1910

9. Birthplace (State or Foreign Country)

Illinois

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8440 Tea Rose Drive

10f. Zip Code

20879

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: World
War II13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Executive Administrator

16b. Kind of Business/Industry

United States
Government

17. Father's Name (First, Middle, Last)

John P. Beckman

18. Mother's Name (First, Middle, Maiden Surname)

Celia Williams

19a. Informant's Name/Relationship (Type, Print)

Mary Helen Beckman / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8440 Tea Rose Drive, Gaithersburg, Maryland 20879

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Arlington National Cemetery

Date

July 9, 1997

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

Barbara J. M. Mulvey

M00831

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Rockville, Inc.
300 West Montgomery Avenue, Rockville, Maryland 20850-280523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Gastrointestinal bleed

Due to (or as a consequence of):

b. renal failure

Due to (or as a consequence of):

c. urinary obstruction

Due to (or as a consequence of):

d. prostate cancer (advanced)

Approximate
Interval Between
Onset and Death

2 days

1 year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

tachycardia
nephrotic

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Rashid Baghai-Naini

29c. License number

D 39372

29d. Date signed (Month, Day, Year)

June 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

344 University Blvd West Suite 324
Silver Spring MD 20901
Rashid Baghai-Naini, M.D.

31. Date filed (Month, Day, Year)

JUL 01, 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21443

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Hugh Bass				2. Date of Death Month Day Year June 27, 1997		3. Time of Death 10:30 AM	
	4a. Facility Name (If not institution, give street and number) 2501 Newglen Avenue				4b. City, Town, or Location of Death Forestville		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 521-30-6777		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 67 Yrs.		8. Date of Birth (Month, Day, Year) January 11, 1930	
	9. Birthplace (State or Foreign Country) Colorado		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Forestville	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 2501 Newglen Avenue		10f. Zip Code 20747		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) musician		16b. Kind of Business/Industry free lance				
17. Father's Name (First, Middle, Last) Rhuben Bass				18. Mother's Name (First, Middle, Maiden Summa) Edith Taylor Barnes				
19a. Informant's Name/Relationship (Type, Print) Jeanne O. Bass				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2501 Newglen Avenue, Forestville, Maryland 20747				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Eksjo Lutheran Church Cem.		Date 7-3-97		20c. Location - City or Town, State Lake Park, Minnesota		
21. Signature of Funeral Service Licensee Carol A. Delm				22. Name and Address of Facility Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Myelogenous Leukemia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and Title of certifier Chohan				29c. License number D33224		29d. Date signed (Month, Day, Year) June 27, 1997		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ram S. Trehan, M.D. 9801 Georgia Avenue #118, Silver Spring, Maryland 20902								
31. Date filed (Month, Day, Year) JUL 02 1997		32. Registrar's Signature Julia Davidson-Randall						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21444

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Evelyn Barnett				2. Date of Death Month Day Year June 29, 1997		3. Time of Death 7:40 PM	
	4a. Facility Name (If not institution, give street and number) Suburban Hospital				4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 053-38-5618		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 17, 1910	
	9. Birthplace (State or Foreign Country) New York		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Chevy Chase	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 8101 Connecticut Avenue		10f. Zip Code 20815		10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Samuel Safran				18. Mother's Name (First, Middle, Maiden Surname) Rose Gold			
	19a. Informant's Name/Relationship (Type, Print) Barbara B. Wing				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7810 Stratford Road, Bethesda, MD 20814			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		20c. Location - City or Town, State Beltsville, Maryland		20d. Date 7-1-97	
	21. Signature of Funeral Service Licensee <i>Ellen H. Rapp</i>				22. Name and Address of Facility Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Myocardial Infarction Due to (or as a consequence of): Coronary Artery Disease Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Approximate Interval Between Onset and Death 3 days 10 years							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <i>Harris M. Kenner MD</i>				29c. License number 706019		29d. Date signed (Month, Day, Year) June 30, 1997		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARRIS M. KENNER, MD. 6410 ROCKLEDGE DRIVE BETHESDA MD 20817								
31. Date filed (Month, Day, Year) JUL 02 1997				32. Registrar's Signature <i>Julia Davidson-Randall</i>				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21445

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Evelyn Waldron Brinsfield			2. Date of Death Month July Day 4 Year 1997		3. Time of Death 6:45 PM	
	4a. Facility Name (If not institution, give street and number) 3632 Lightner Court			4b. City, Town, or Location of Death Waldorf		4c. County of Death Charles	
Funeral Director	5. Social Security Number 214-90-6230		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 7, 1912
	9. Birthplace (State or Foreign Country) Florida						
To Be Completed by Funeral Director	10a. State Maryland		10b. County Charles		10c. City, Town or Location Waldorf		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 3632 Lightner Court			10f. Zip Code 20602		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Home		
	17. Father's Name (First, Middle, Last) Marvin Waldron			18. Mother's Name (First, Middle, Maiden Surname) Susie Emma Bain Waldron			
	19a. Informant's Name/Relationship (Type, Print) Flavius Brinsfield/ Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3632 Lightner Ct. Waldorf, MD 20602			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory 7/5		20c. Location - City or Town, State Alexandria, VA		
	21. Signature of Funeral Service Licensee M00817 <i>Rayton C. Echols III</i>		22. Name and Address of Facility Arehart-Echols Funeral Home P.O. Box 567 La Plata, MD 20646				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CORONARY ARTERY DISEASE Due to (or as a consequence of): b. DIABETIS MELLITUS Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <i>Keith W. McOm</i>			29c. License number 028352		29d. Date signed (Month, Day, Year) 7/5/97		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P O Box 2729 La Plata Md. 20646							
31. Date filed (Month, Day, Year) JUL 07 1997		32. Registrar's Signature <i>Julia Davidson Randall</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21446

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Finis R. Burkhardt				2. Date of Death Month Day Year June 25, 1997		3. Time of Death 5:00 AM	
	4a. Facility Name (If not institution, give street and number) Doctors Community Hospital				4b. City, Town, or Location of Death Lanham		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 310 24 0855		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 6, 1908	9. Birthplace (State or Foreign Country) Indiana
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Prince George's	10c. City, Town or Location Bowie			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 13204 Idlewild Drive			10f. Zip Code 20715		10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineer		16b. Kind of Business/Industry Wabash College			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) James C. Burkhardt				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Jane McCauley			
	19a. Informant's Name/Relationship (Type, Print) Robert R. Burkhardt Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13204 Idlewild Drive Bowie Maryland 20715				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date June 27, 1997		20c. Location - City or Town, State Alexandria Va.	
	21. Signature of Funeral Service Licensee <i>Michael L. Bigler</i>		22. Name and Address of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Md. 20715					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multi drug resistant staph aureous pneumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							Approximate Interval Between Onset and Death One week
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Parkinsonism.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
Medical Certification: To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier ► Rountin Farahi		29c. License number D4 3446		29d. Date signed (Month, Day, Year) 6.25.97	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROINTAN FARABI FAR M.O. 4000 Mitchellville road B216 Bowie MD 20716							
	31. Date filed (Month, Day, Year) JUN 30 1997		32. Registrar's Signature <i>John D. ...</i>					



- Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21447

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) ERIC EDWARD BROOKS				2. Date of Death Month Day Year JUNE 26 97		3. Time of Death 11:05 PM			
4e. Facility Name (If not institution, give street and number) PRINCE GEORGE COUNTY GENERAL HOSPITAL				4b. City, Town, or Location of Death CHEVERLY		4c. County of Death PG			
5. Social Security Number 578-70-8475		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 43 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 2/21/54		9. Birthplace (State or Foreign Country) WASHINGTON, DC	
Usual Residence of Decedent									
10a. State DC		10b. County N/A		10c. City, Town or Location WASHINGTON				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 1553 ANACOSTIA AVENUE NE #14				10f. Zip Code 20019		10g. Citizen of What Country? USA			
11. Marital Status SINGLE 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YEARS College (1-4 or 5+) NONE				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) UNEMPLOYED		16b. Kind of Business/Industry NONE			
17. Father's Name (First, Middle, Last) ROBERT E. BROOKS				18. Mother's Name (First, Middle, Maiden Surname) SHIRLEY SIMPSON					
19a. Informant's Name/Relationship (Type, Print) SHIRLEY A. BROOKS				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS 10A, B, C, D, E, & F					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) 7/2/97 HARMONY MEMORIAL PARK CEMETERY		20c. Location - City or Town, State LANDOVER, MD.					
21. Signature of Funeral Service Licensee [Signature]				22. Name and Address of Facility JOHN T. RHINES CO., INC. 3030 12TH ST NE, DC 20017					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Cardiac Pump Failure/Arrest Due to (or as a consequence of): b. Alcoholic Cardiomyopathy Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 5 MIN					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Liver Failure Secondary to Alcohol				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier [Signature]		29c. License number D21428		29d. Date signed (Month, Day, Year) June 27, 1997			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) LINDA GREEN 3001 HOSPITAL DR. CHEV. MD. 20785									
31. Date filed (Month, Day, Year) JUL 01 1997				32. Registrar's Signature [Signature]					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21448

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elnora Braswell				2. Date of Death Month June Day 28 Year 97		3. Time of Death 9 PM	
	4a. Facility Name (If not institution, give street and number) Deaton Umms				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore Co.	
Funeral Director	5. Social Security Number 578-64-8681		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 51 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 11, 1946	9. Birthplace (State or Foreign Country) Wilson, N.C.
	Usual Residence of Decedent							
10a. State MD		10b. County Prince George's		10c. City, Town or Location Temple Hill			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 2503 Oxon Run Drive				10f. Zip Code 20748		10g. Citizen of What Country? United States America		
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Executive Secretary			16b. Kind of Business/Industry Private	
17. Father's Name (First, Middle, Last) James Braswell				18. Mother's Name (First, Middle, Maiden Surname) Anne L. Foster				
19a. Informant's Name/Relationship (Type, Print) Anne L. Braswell / Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2503 Oxon Run Drive, Temple Hill, MD 20748				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park		Date 7/3/97		20c. Location - City or Town, State Landover, Maryland
21. Signature of Funeral Service Licensee Glenda M. Freeman				22. Name and Address of Facility Sterling Funeral Services 1601 Kenilworth Avenue, NE; Washington, DC				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Acute Respiratory Failure Due to (or as a consequence of): b. Rheumatoid Arthritis, severe Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Psychosis, NOC Malnutrition Anemia						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier C. Earl Hill, M.D.		29c. License number D-06204		29d. Date signed (Month, Day, Year) June 30, 1997		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. Earl Hill, M.D. 611 S. Charles Street Baltimore, Md. 21230								
31. Date filed (Month, Day, Year) JUL 02 1997								
32. Registrar's Signature John [Signature]								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

BETTY
CORBY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21449

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Betty Lou CORBY			2. Date of Death Month Day Year JUNE 25 1997			3. Time of Death 10:46 P.M.				
	4a. Facility Name (If not institution, give street and number) GARRETT COUNTY MEMORIAL HOSPITAL			4b. City, Town, or Location of Death OAKLAND			4c. County of Death GARRETT COUNTY				
Funeral Director	5. Social Security Number 213-72-1790		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 40 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 10, 1956		9. Birthplace (State or Foreign Country) West Virginia		
	10e. State MD			10b. County Garrett			10c. City, Town or Location Oakland			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 348 Snow Dump Mountain Road			10f. Zip Code 21550			10g. Citizen of What Country? USA				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)			16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse's Aide			16b. Kind of Business/Industry Private Care				
	17. Father's Name (First, Middle, Last) Clarence Edward McRobie			18. Mother's Name (First, Middle, Maiden Surname) Edna Irene Sharpless							
	19a. Informant's Name/Relationship (Type, Print) A. Craig Corby, Husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 348 Snow Dump Mtn. Road, Oakland, MD 21550							
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Omega Crematory			Date 6/29/97		20c. Location - City or Town, State Morgantown, WV		
	21. Signature of Funeral Service Licensee Bradley H. Stewart			22. Name and Address of Facility Stewart Funeral Home 32 S. Second St., Oakland, MD 21550							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									Approximate Interval Between Onset and Death Sudden	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
										24e. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year) 6-25-97		28b. Time of Injury 2205 M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Driver in auto accident	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) STREET			28f. Location (Street and Number or Rural Route Number, City or Town, State) Rte. 560 (near S of Lf Lynn)				
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier J. LARON LOCKE, MD			29c. License number O.C.M.E.			29d. Date signed (Month, Day, Year) JUNE 26, 1997	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. LARON LOCKE, MD			111 Penn Street, Baltimore, Maryland 21201							
	31. Date filed (Month, Day, Year) JUL 2 1997			32. Registrar's Signature J. L. Anderson-Randall							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,


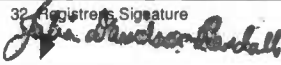
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21450

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HELEN REED CLARK				2. Date of Death Month June Day 29 Year 1997		3. Time of Death 7:20 PM	
	4a. Facility Name (If not institution, give street and number) Fallston General Hospital				4b. City, Town, or Location of Death Fallston		4c. County of Death Harford	
Funeral Director	5. Social Security Number 213-38-6487	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 97 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 19, 1899		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent				10a. State Maryland		10b. County Harford	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 29 Homestead Street		10f. Zip Code 21014		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Harry Reed Coale				18. Mother's Name (First, Middle, Maiden Surname) Sarah Estell Kerr			
	19a. Informant's Name/Relationship (Type, Print) Samuel Magness - Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29 Homestead Street, Bel Air, Maryland 21014			
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bel Air Memorial Gardens		Date 7-2-97		20c. Location - City or Town, State Bel Air, Maryland	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Md. 21009					
	23e. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE HEART FAILURE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Approximate Interval Between Onset and Death 5 days							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Recurrent Pyelonephritis, Staghorn Calculus, Encephalopathy.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier 						
29c. License number D35012		29d. Date signed (Month, Day, Year) JUNE 30, 1997						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Kevin Lynch M.D. 2 North Ave. Bel Air, Md. 21014								
31. Date filed (Month, Day, Year) JUL 1 1997		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Helen, Coale Clark
Division of Vital Records, P.O. Box 68760,State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21451

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PATRICIA CARR		2. Date of Death Month JUNE Day 28 Year 1997		3. Time of Death 9:05 PM
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital		4b. City, Town, or Location of Death Takoma Park		4c. County of Death Montgomery
Funeral Director	5. Social Security Number 424-64-5386	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 63 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) May 7, 1934		9. Birthplace (State or Foreign Country) Guyane		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State Md.		10b. County P.G.
	10c. City, Town or Location Lanham		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 7528 Wilhelm Dr.		10f. Zip Code 20706		10g. Citizen of What Country? U.S.A.
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Associate Specialist Underwriting Insurance
	16b. Kind of Business/Industry		17. Father's Name (First, Middle, Last) Dorset T. Carr		18. Mother's Name (First, Middle, Maiden Surname) Dorothy VanSluytman
	19a. Informant's Name/Relationship (Type, Print) Claudette Carr (Sister)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7528 Wilhelm Dr. Lanham, Md. 20706		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) George Washington Cemetery 7/7		20c. Location - City or Town, State Adelphi, Md.
	21. Signature of Funeral Service Licensee <i>Thomas S. Chamber</i>		22. Name and Address of Facility Chambers Funeral Homes, P.A. 5801 Cleveland Ave. Riverdale, Md. 20737		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive Heart Failure Due to (or as a consequence of): b. Hypertension - 3/4 p Chemotherapy Due to (or as a consequence of): c. Breast Cancer with Due to (or as a consequence of): d. Metastasis				
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day, Year) 6/29/97					
28b. Time of Injury M					
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <i>Samuel L. [Signature]</i>					
29c. License number D19935					
29d. Date signed (Month, Day, Year) 6/29/97					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 7610 Carroll Ave. Takoma Park, MD 20912					
31. Date filed (Month, Day, Year) JUL 01 1997					
32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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148

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State of Maryland / Department of Health and Mental Hygiene

97 21452

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Nancy Chow

2. Date of Death
Month Day Year
June 26, 19973. Time of Death
7:20 A.M.

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director5. Social Security Number
213-56-66706. Sex
1 ☐ M 2 ☒ F7. Age (In yrs. last birthday)
76 Yrs.If Under 1 Year
Months DaysIf Under 24 Hrs.
Hours Min.8. Date of Birth
(Month, Day, Year)
June 7, 19219. Birthplace (State or Foreign
Country)
China

Usual Residence of Decedent

10a. State
MD10b. County
Montgomery10c. City, Town or Location
Chevy Chase,10d. Inside City Limits
1 ☒ Yes 2 ☐ No

10e. Street and Number

4701 Willard Ave. #217

10f. Zip Code

20815

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify: Asian14. Race - American Indian,
Black, White, etc.
Specify: Asian15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) 4 College (1-4 or 5+)16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Programmer16b. Kind of Business/Industry
National Education
Foundation

17. Father's Name (First, Middle, Last)

Tsao

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Diane Lu Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

611 S. Vista Avenue, Alhambra, California 91801

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Gate Of Heaven Cemetery

Date

6/30/97

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

Joseph M. Peters

22. Name and Address of Facility

Joseph Gawler's Sons Inc.

5130 Wisconsin Avenue, NW, Washington, D.C. 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a.

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter underlying
cause (Disease or injury
that initiated events
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury
M28c. Injury et
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Gita Bakshi

29c. License number

023170

29d. Date signed (Month, Day, Year)

June 26, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Gita Bakshi, M.D. 9406 Old Georgetown Road, Bethesda, MD 20814

31. Date filed (Month, Day, Year)

JUN 30 1997

32. Registrar's Signature

*Julia Davidson-Rendell*State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21453

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carol Anne Clark				2. Date of Death Month Day Year June 30, 1997		3. Time of Death 5:45 PM								
	4a. Facility Name (If not institution, give street and number) 10204 Crested Iris Drive				4b. City, Town, or Location of Death Gaithersburg		4c. County of Death Montgomery								
Funeral Director	5. Social Security Number 355-32-1369		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 56 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 23, 1940		9. Birthplace (State or Foreign Country) Illinois						
	Usual Residence of Decedent														
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Gaithersburg				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
10e. Street and Number 10204 Crested Iris Drive				10f. Zip Code 20879		10g. Citizen of What Country? United States									
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Budget Officer			16b. Kind of Business/Industry Dept. of Justice								
17. Father's Name (First, Middle, Last) Arthur James Collins					18. Mother's Name (First, Middle, Maiden Surname) Esther Dorothy Dell										
19a. Informant's Name/Relationship (Type, Print) Joanne E. Clark					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10										
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		Date 7-1-97		20c. Location - City or Town, State Beltsville, Maryland								
21. Signature of Funeral Service Licensee Ellen H. Rapp					22. Name and Address of Facility Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Breast Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 5 years					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred					
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier Stephen Staal MD		29c. License number D18912		29d. Date signed (Month, Day, Year) July 1, 1997	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen Staal, M. D., 10810 Connecticut Avenue, Kensington, MD 20895															
31. Date filed (Month, Day, Year) JUL 02 1997				32. Registrar's Signature Julia Davidson-Randall											

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21454

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LUCY FRANCES COLEMAN				2. Date of Death Month JUNE Day 24 Year 1997		3. Time of Death 1407 pm												
	4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL				4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY												
Funeral Director	5. Social Security Number 235-80-3355		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 48 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) MAY 21, 1949	9. Birthplace (State or Foreign Country) West VA											
	Usual Residence of Decedent				10e. State MD		10b. County Montgomery		10c. City, Town or Location Rockville										
To Be Completed by Funeral Director	10e. Street and Number 316 Lincoln Avenue		10f. Zip Code 20850		10g. Citizen of What Country? U.S.A.		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No												
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black												
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry None														
	17. Father's Name (First, Middle, Last) Lloyd Lipscomb				18. Mother's Name (First, Middle, Maiden Surname) Mary M. Austin														
	19a. Informant's Name/Relationship (Type, Print) Henry R. Austin (Brother)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 175, Hemphill, WV 23842														
	20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lincoln Park Cem.		Date 7/1/97		20c. Location - City or Town, State Rockville, MD												
	21. Signature of Funeral Service Licensee <i>George R. [Signature]</i>				22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850														
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																		
	<table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>INTRACRANIAL hemorrhage</td> <td rowspan="4"> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. </td> <td rowspan="4"> Approximate Interval Between Onset and Death 2 days </td> </tr> <tr><td>b.</td><td></td></tr> <tr><td>c.</td><td></td></tr> <tr><td>d.</td><td></td></tr> </table>								Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	INTRACRANIAL hemorrhage	Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.	Approximate Interval Between Onset and Death 2 days	b.		c.		d.	
	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	INTRACRANIAL hemorrhage	Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.	Approximate Interval Between Onset and Death 2 days														
b.																			
c.																			
d.																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Diabetes Cerebrovascular Accidents						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown													
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred											
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)																	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																			
29b. Signature and title of certifier <i>Dr. [Signature]</i>		29c. License number D18726		29d. Date signed (Month, Day, Year) June 25, 1997															
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ARTHUR SCHWENGLER, MD 9715 MEDICAL Center Dr. Rockville, MD 20850																			
31. Date filed (Month, Day, Year) JUL 02 1997		32. Registrar's Signature <i>John Davidson-Randall</i>																	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21455

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Reita L. Crowe

2. Date of Death
Month Day Year
June 29, 19973. Time of Death
12:45 AM

4a. Facility Name (If not institution, give street and number)

Collingswood Nursing Home

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

243-76-1056

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 23, 1907

9. Birthplace (State or Foreign Country)

Tennessee

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

North Potomac

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11220 Freas Drive

10f. Zip Code

20878

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Thadeus E. Lawson

18. Mother's Name (First, Middle, Maiden Surname)

Bertie M. Thurman

19a. Informant's Name/Relationship (Type, Print)

Carole C. McCloud/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11220 Freas Drive, North Potomac, Maryland 20878

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chattanooga Memorial Park

Date

July 3, 1997

20c. Location - City or Town, State

Chattanooga, Tennessee

21. Signature of Funeral Service Licensee

Michele P. Kutta

M00348

22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/
Rockville Inc. 300 West Montgomery Avenue,
Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Cardiovascular Disease

Approximate Interval Between Onset and Death
April 1992-Present

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒2 ☐

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Myron L. Lenkin MD

29c. License number

D06674

29d. Date signed (Month, Day, Year)

6/30/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MYRON L. LENKIN MD

2309 SHOREFIELD RD
WHEATON MD 2090

31. Date filed (Month, Day, Year)

JUL 03 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21456

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RIVY CUTLER				2. Date of Death Month JUNE 30, Day 1997 Year		3. Time of Death 11:55AM	
	4a. Facility Name (If not institution, give street and number) 1401 BLAIR MILL ROAD # 319				4b. City, Town, or Location of Death SILVER SPRING		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 040-22-7968		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		8. Date of Birth (Month, Day, Year) JAN. 23, 1907	
	9. Birthplace (State or Foreign Country) NY		10a. State MD		10b. County MONTGOMERY		10c. City, Town or Location SILVER SPRING	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 1401 BLAIR MILL ROAD, #319		10f. Zip Code 20910		10g. Citizen of What Country? UNITED STATES	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TEACHER		16b. Kind of Business/Industry EDUCATION			
	17. Father's Name (First, Middle, Last) RABBI JOSEPH NATHAN ROSENBERG				18. Mother's Name (First, Middle, Maiden Surname) MARION SERLING			
	19a. Informant's Name/Relationship (Type, Print) HERSCHEL CUTLER / SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11409 MARCLIFF ROAD, ROCKVILLE, MD 20852			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BETH SHOLOM CEMETERY		Date 7/1/97		20c. Location - City or Town, State CAPITOL HEIGHTS, MD	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. CEREBRAL VASCULAR ACCIDENT Due to (or as a consequence of): b. CEREBRAL ARTERIOSCLEROSIS Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 3 WEEKS 2 YEARS							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier 				29c. License number D07568		29d. Date signed (Month, Day, Year) JUNE 30, 1997		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DR. FREDERICK MEYERS, 2440 M. ST., NW, #417, WASHINGTON, D.C. 20037								
31. Date filed (Month, Day, Year) JUL 03 1997								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21457

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Wilfred J. Coupal

2. Date of Death

June 27, 1997

3. Time of Death

1:17 A.M.

Funeral
Director

4e. Facility Name (If not institution, give street and number)

7216 Roanne Dr.

4b. City, Town, or Location of Death

Oxon Hill

4c. County of Death

Prince George's

5. Social Security Number

224-50-2599

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 25, 1918

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Oxon Hill

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

7216 Roanne Dr.

10f. Zip Code

20745

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

☒ Yes ☐ No
If Yes, Give
Year or Dates: 1940-6413. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
11

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Military

16b. Kind of Business/Industry

U.S. Navy

17. Father's Name (First, Middle, Last)

Frederick Coupal

18. Mother's Name (First, Middle, Maiden Surname)

Leocardia Fontaine

19a. Informant's Name/Relationship (Type, Print)

Rita M. Coupal/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7216 Roanne Dr. Oxon Hill, Md. 20745

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☒ Other (Specify) Entombment20b. Place of Disposition (Name of
cemetery, crematory or other place)

Resurrection Cem.

Date

6/30/97

20c. Location - City or Town, State

Clinton, Maryland

21. Signature of Funeral Service Licensed

22. Name and Address of Facility

George P. Kalas Funeral Home
6160 Oxon Hill Rd., Oxon Hill, Md. 2074523e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Esophageal Cancer
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

2 weeks

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Lastb. _____
Due to (or as a consequence of):c. _____
Due to (or as a consequence of):d. _____
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home ☐ Residence ☒ Other (Specify) Home

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be
☐ Suicide ☐ Could not be
☐ Homicide ☐ datamined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D-24535

29d. Date signed (Month, Day, Year)

6/28/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Laxmi N. Berwa, M.D. 7700 Old Branch Ave. #C101, Clinton, Md. 20735

31. Date filed (Month, Day, Year)

JUN 30 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
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once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

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within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

THE END

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21458

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Robert Colister, Sr.

2. Date of Death

Month
JuneDay
23Year
1997

3. Time of Death

2:52 AM

4a. Facility Name (If not institution, give street and number)

Doctor's Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

5. Social Security Number

213-12-5124

6. Sex

XX Male ☐ Female

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

March 1, 1920

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

College Park

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

5904 Bryn Mawr Road

10f. Zip Code

20740

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12College (14 or 5+)
2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Police Officer

16b. Kind of Business/Industry

Maryland State Police

17. Father's Name (First, Middle, Last)

Robert Earl Colister

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude C. Slavin

19a. Informant's Name/Relationship (Type, Print)

Ruth Virginia Colister (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as #10

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington National Cemetery

Date

6/27/1997

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

Donald V. Borgwardt

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.
4400 Powder Mill Road Beltsville, Maryland 20705

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Electromechanical Dissociation

Due to (or as a consequence of):

b. Myocardial Ischemia

Due to (or as a consequence of):

c. Coronary Artery Disease

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

30 minutes

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Prostate Cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael Schwartz MD

29c. License number

D22117

29d. Date signed (Month, Day, Year)

6/23/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Schwartz, MD 7500 Hanover Parkway, Suite 204, Greenbelt, MD 20770

31. Date filed (Month, Day, Year)

JUN 30 1997

32. Registrar's Signature

John Andrew Ricketts

State
Registrar

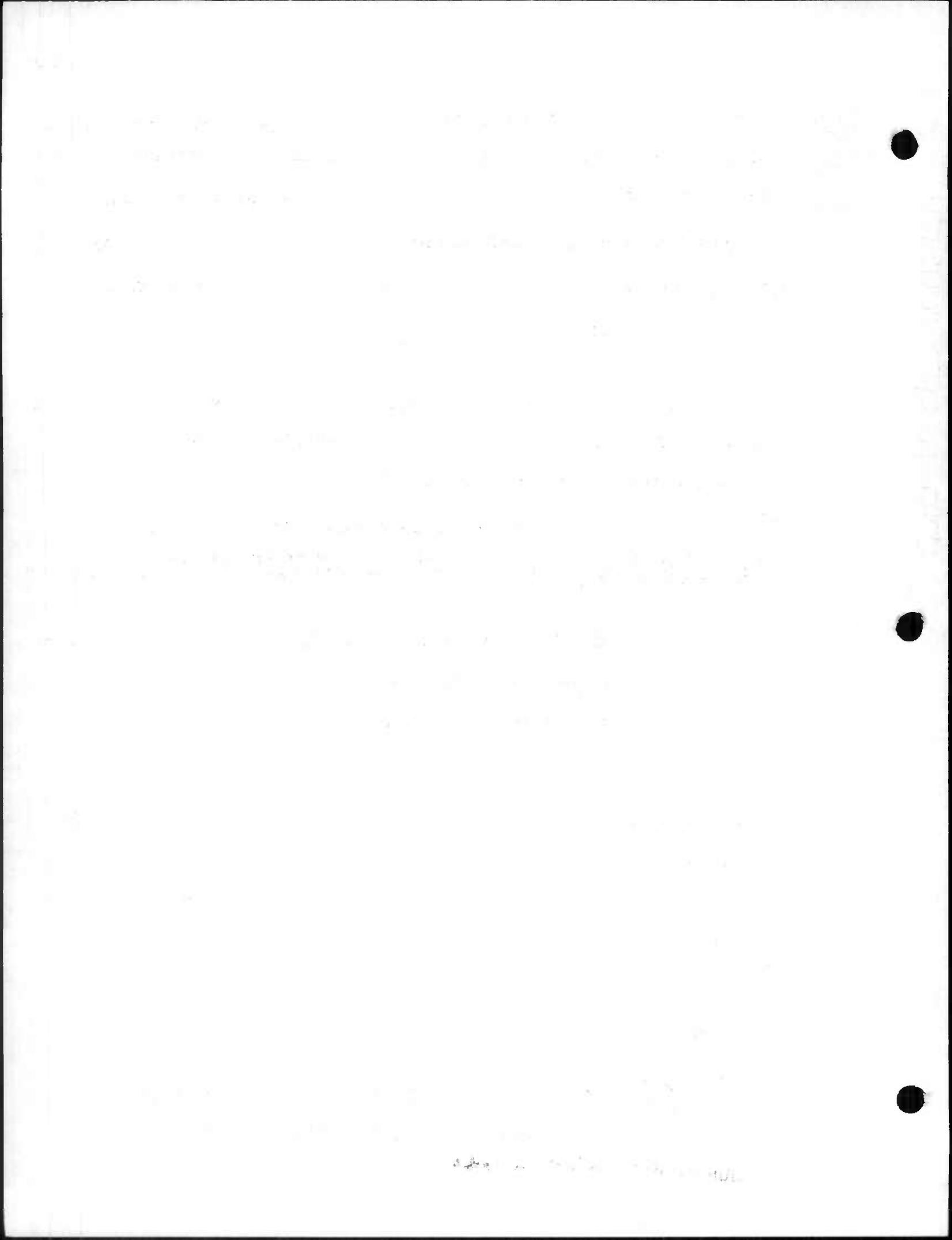
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21459

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ERNEST W. CRAWFORD

2. Date of Death

Month Day Year
JUNE 27-1997

3. Time of Death

10:48 am

4a. Facility Name (If not institution, give street and number)

SOUTHERN MARYLAND HOSPITAL

4b. City, Town, or Location of Death

Clinton

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

409-38-7743

6. Sex

XX M 20 F

7. Age (In yrs. last birthday)

70

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 01, 1926

9. Birthplace (State or Foreign Country)

Alcoa, TN

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges'

10c. City, Town or Location

Clinton

10d. Inside City Limits

1XXes 20 No

10e. Street and Number

11121 Piscataway Road

10f. Zip Code

20735

10g. Citizen of What Country?

USA

11. Marital Status

10 Never Married XX Married
30 Widowed 40 Divorced

12. Was Decedent Ever in U.S.

10 Yes 20 No
If Yes, Give Year or Dates: 194613. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 20 No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Utility Specialist

16b. Kind of Business/Industry

Philadelphia Gas Work

17. Father's Name (First, Middle, Last)

Robert Crawford

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Thorpe

19a. Informant's Name/Relationship (Type, Print)

Agnes Crawford/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11121 Piscataway Road Clinton, Md. 20735

20a. Method of Disposition

XX Burial 20 Cremation 30 Removal from State
40 Donation 50 Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Harmony Memorial Park

Date

07/02/97

20c. Location - City or Town, State

Landover, Md.

21. Signature of Funeral Service Licensee

Philly Bell

22. Name and Address of Facility

Robert G. Mason Funeral Home, Inc.

1661 Good Hope Road, S.E. Wash., DC 20020

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. CARCINOMA LUNG

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

2 YEARS

Sequitally list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy
performed?

10 Yes 20 No

24b. Were autopsy findings
available prior to
completion of cause
of death?

10 Yes 20 No

25. Was case referred to medical
examiner?

10 Yes 20 No

26. Place of Death (Check only one)

Hospital:

10 Inpatient

20 ER/Outpatient

30 DOA

Other:

40 Nursing Home

50 Residence

60 Other (Specify)

27. Manner of Death

10 Natural 50 Pending
20 Accident investigation
30 Suicide 60 Could not be
40 Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury et Work?

10 Yes 20 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)

XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Kenneth Ranson

29c. License number

D30135

29d. Date signed (Month, Day, Year)

6-27-1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kenneth Ranson So. MD Hosp. Clinton Md

31. Date filed (Month, Day, Year)

JUL 02 1997

32. Registrar's Signature

John Andrew Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Handwritten text, possibly a signature or date.

41 30 JUL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21460

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Violet K. Caboga				2. Date of Death Month Day Year June 26 1997		3. Time of Death 7:00 AM														
	4a. Facility Name (If not institution, give street and number) Doctors Community Hospital				4b. City, Town, or Location of Death Lanham		4c. County of Death Prince Georges														
Funeral Director	5. Social Security Number 575 44 8669	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 55 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 5, 1942	9. Birthplace (State or Foreign Country) Hawaii														
	Usual Residence of Decedent																				
To Be Completed by Funeral Director	10a. State Maryland	10b. County Prince George's	10c. City, Town or Location Bowie			10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No															
	10e. Street and Number 15019 Nighthawk Lane			10f. Zip Code 20716		10g. Citizen of What Country? United States															
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White														
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Executive Assistant			16b. Kind of Business/Industry Beverage Distributor															
	17. Father's Name (First, Middle, Last) Kiyoshi Kawasaki				18. Mother's Name (First, Middle, Maiden Surname) Ishiko Oshikata																
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Ann F. Kawasaki Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15019 Nighthawk Lane Bowie Maryland 20716																
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State June 28, 1997 Alexandria Virginia		20d. Date														
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Md. 20715																		
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each line.																				
	<table border="0"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Cerebral Edema</td> <td>Approximate Interval Between Onset and Death</td> <td>3 Days</td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</td> <td>b. Due to (or as a consequence of): Cerebrovascular Accident</td> <td></td> <td>7 Days</td> </tr> <tr> <td>c. Due to (or as a consequence of): Atherosclerosis</td> <td></td> <td>Years</td> </tr> <tr> <td>d. Due to (or as a consequence of): Diabetes Mellitus</td> <td></td> <td>Years</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. Cerebral Edema	Approximate Interval Between Onset and Death	3 Days	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Cerebrovascular Accident		7 Days	c. Due to (or as a consequence of): Atherosclerosis		Years	d. Due to (or as a consequence of): Diabetes Mellitus	
Immediate Cause (Final disease or condition resulting in death)	a. Cerebral Edema	Approximate Interval Between Onset and Death	3 Days																		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Cerebrovascular Accident		7 Days																		
	c. Due to (or as a consequence of): Atherosclerosis		Years																		
	d. Due to (or as a consequence of): Diabetes Mellitus		Years																		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Right Carotid Endarterectomy THROMBOSIS LEFT common carotid artery						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown														
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No															
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred																			
28f. Location (Street and Number or Rural Route Number, City or Town, State)																					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																					
29b. Signature and title of certifier <i>[Signature]</i>		29c. License number 023586		29d. Date signed (Month, Day, Year) 6/27/97																	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Brian S Bayly MD 7223 Hammen Parkway Greenbelt Md 20770																					
31. Date filed (Month, Day, Year) JUL 02 1997		32. Registrar's Signature <i>[Signature]</i>																			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21461

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Francis Dyer, Jr.

2. Date of Death

Month Day Year
June 28, 1997

3. Time of Death

10:33AM

4a. Facility Name (If not institution, give street and number)

7805 Fulbright Court

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

025-18-9819

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept. 7, 1925

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7805 Fulbright Court

10f. Zip Code

20817

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ NoIf Yes, Give
Year or Dates: World
War II13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify:

White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Consultant

16b. Kind of Business/Industry

Marketing

17. Father's Name (First, Middle, Last)

John F. Dyer, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Josephine S. Colgan

19a. Informant's Name/Relationship (Type, Print)

Audrey L. Dyer / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7805 Fulbright Court, Bethesda, Maryland 20817

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Montgomery Crematorium, Inc.

Date

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

M00831

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.
7557 Wisconsin Avenue, Bethesda, Maryland 20814-350123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Coronary Artery Disease

Due to (or as a consequence of):

b. Ventricular Arrhythmia

Due to (or as a consequence of):

c. Peripheral Vascular Disease

Due to (or as a consequence of):

d.

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D25818

29d. Date signed (Month, Day, Year)

June 30, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sean M. Dwyer, M.D. 5454 Wisconsin Avenue, #925, Chevy Chase, Maryland 20815

31. Date filed (Month, Day, Year)

JUL 01 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21462

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Viola M. Doolittle

2. Date of Death

June 28 1997

3. Time of Death

11:07 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

577-03-7828

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Mar. 27, 1909

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

437 Northwest Drive

10f. Zip Code

20901

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Executive Assistant

16b. Kind of Business/Industry

Hotel

17. Father's Name (First, Middle, Last)

Willard E. Owens

18. Mother's Name (First, Middle, Maiden Surname)

Anne Carrico

19a. Informant's Name/Relationship (Type, Print)

Raymond E. Doolittle / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16909 George Washington Drive, Rockville, MD 20853

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Cedar Hill Cemetery

Date

7/2/97

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hines-Rinaldi Funeral Home
11800 New Hampshire Avenue
Silver Spring, Maryland 2090423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Cardiac Arrest

Due to (or as a consequence of):

b. Coronary Artery Disease

• Due to (or as a consequence of):

c. Atherosclerosis

Due to (or as a consequence of):

d. Severe Ischemia Right Lower Extremity
Metastatic Colon Ca.Approximate
Interval Between
Onset and Death

hours

year

year

hours

year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Metastatic Colon Ca

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

MD000025765 D.C.

29d. Date signed (Month, Day, Year)

6/29/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5530 Wisconsin Ave. Chevy Chase, Md. 20815

31. Date filed (Month, Day, Year)

JUL 01 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21463

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Franzetta R. De Gooyer				2. Date of Death Month July Day 1 Year 1997		3. Time of Death 2:25 PM		
	4a. Facility Name (If not institution, give street and number) Wilson Health Care Center				4b. City, Town, or Location of Death Gaithersburg		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 577-28-1426		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 8, 1913	9. Birthplace (State or Foreign Country) Utah	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Bethesda			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 7111 Thomas Branch Drive				10f. Zip Code 20817		10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) 12 Elementary/Secondary (0-12) College (1-4 or 5+)		18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Professional Staff Member			16b. Kind of Business/Industry Federal Government			
	17. Father's Name (First, Middle, Last) Morgan Richards				18. Mother's Name (First, Middle, Maiden Surname) Sarah Butler				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) John G. DeGooyer (Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7111 Thomas Branch Drive, Bethesda, MD 20817				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cemetery 7/8/1997 Arlington, VA		Date		20c. Location - City or Town, State		
	21. Signature of Funeral Service Licensee Michael D. Gibbons				22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Alzheimer's disease Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier James R. Moore Jr. MD		29c. License number 07231		29d. Date signed (Month, Day, Year) July 1 1997			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) James R. Moore Jr. 207 Brooker Ave Gaithersburg MD 20877									
31. Date filed (Month, Day, Year) JUL 03 1997				32. Registrar's Signature John Davidson					

Baltimore, Maryland 21215-0020

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21464

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BURNELL DAVIS				2. Date of Death Month Day Year JUNE 26 1997		3. Time of Death 5:20 pm										
	4a. Facility Name (If not institution, give street and number) FORT WASHINGTON HOSPITAL				4b. City, Town, or Location of Death FORT WASHINGTON		4c. County of Death PRINCE GEORGE'S										
Funeral Director	5. Social Security Number 433-82-3821		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 45 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 11, 1951	9. Birthplace (State or Foreign Country) Louisiana									
	Usual Residence of Decedent																
To Be Completed by Funeral Director	10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Fort Washington		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
	10e. Street and Number 900 Lira Drive				10f. Zip Code 20744		10g. Citizen of What Country? U.S.A.										
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates 1971-97		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify Black										
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Military		16b. Kind of Business/Industry U.S. Air Force										
	17. Father's Name (First, Middle, Last) Leonard Davis, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Ceola Chatman												
	19a. Informant's Name/Relationship (Type, Print) Shanita Sims/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 Lira Dr., Ft. Washington, Md. 20744												
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cem.		20c. Location - City or Town, State 7/3/97 Cheltenham, Maryland												
	21. Signature of Funeral Service Licensee <i>George P. Kalas</i>				22. Name and Address of Facility George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745												
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.																
	<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Hepatic Failure</td> <td rowspan="4">Approximate Interval Between Onset and Death 1 month</td> </tr> <tr> <td>b.</td> <td>Metastatic Colon Cancer</td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Hepatic Failure	Approximate Interval Between Onset and Death 1 month	b.	Metastatic Colon Cancer	c.		d.
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Hepatic Failure	Approximate Interval Between Onset and Death 1 month														
	b.	Metastatic Colon Cancer															
	c.																
	d.																
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown											
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No											
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)															
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No											
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																	
29b. Signature and title of certifier <i>Keith Benton MD</i>				29c. License number 036562		29d. Date signed (Month, Day, Year) 6/27/97											
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>Keith Benton MD 11701 Livingston Rd # 309 Fort Washington MD 20744</i>																	
31. Date filed (Month, Day, Year) JUN 30 1997		32. Registrar's Signature <i>John Anderson</i>															

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21465

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIE DORSEY				2. Date of Death Month: June Day: 25 Year: 1997		3. Time of Death 10:42 P.M.	
	4a. Facility Name (If not institution, give street and number) PRINCE GEORGES HOSPITAL CENTER				4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 579-09-5321	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min.	8. Date of Birth (Month, Day, Year) July 4, 1910	9. Birthplace (State or Foreign Country) Washington, D.C.	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Prince George's	10c. City, Town or Location Cheverly			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number Gladys Spellman Nursing Center 2900 Mercy Lane			10f. Zip Code 20785		10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse-Companion		16b. Kind of Business/Industry Private			
	17. Father's Name (First, Middle, Last) Sherman Wilson				18. Mother's Name (First, Middle, Maiden Surname) Sally Ricks			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Delia M. Campbell - Friend			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 616 Ritchie Avenue, Silver Spring, MD 20910				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Moses Cemetery		Date 7/2/97	20c. Location - City or Town, State Lothian, MD		
	21. Signature of Funeral Service Licensee John T. Stewart III			22. Name and Address of Facility STEWART FUNERAL HOME, Inc. 4001 Benning Road, N. E., Washington, D. C.				
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sepsis							Approximate Interval Between Onset and Death 5 Days
	23b. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Hypotension							Approximate Interval Between Onset and Death 48 Hrs.
23c. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acute Renal Failure							Approximate Interval Between Onset and Death 24 Hrs.	
23d. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CVA. Dysphagia. Decubitus ulcers. M.I. Chronic Bed Ridden.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier P. S. Rutka M.D.		29c. License number D42580		29d. Date signed (Month, Day, Year) 6-26-97		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) P.S. RUTKA M.D. 5632 ANNAPOLIS RD #13 BLADENBURG MD 20710								
31. Date filed (Month, Day, Year) JUL 02 1997		32. Registrar's Signature John A. Wilson						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

July

1944

1944

1. 1. 1944

1. 1. 1944

2. 1. 1944

2. 1. 1944

3. 1. 1944

3. 1. 1944

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4. 1. 1944

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5. 1. 1944

6. 1. 1944

7. 1. 1944

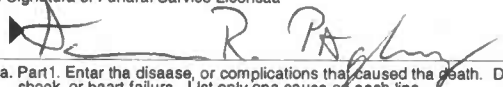
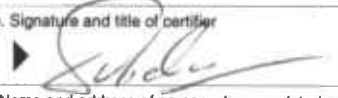
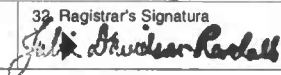
8. 1. 1944

9. 1. 1944

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97 21466

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PEARL M. DODGE				2. Date of Death Month June Day 27 Year 1997				3. Time of Death 8:45pm		
	4a. Facility Name (If not Institution, give street and number) PRINCE GEORGES HOSPITAL CENTER				4b. City, Town, or Location of Death CHEVERLY				4c. County of Death PRINCE GEORGES		
Funeral Director	5. Social Security Number 579-28-7095		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 96 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		
	8. Date of Birth (Month, Day, Year) JUNE 28, 1900		9. Birthplace (State or Foreign Country) VIRGINIA								
Usual Residence of Decedent											
10a. State MARYLAND			10b. County PRINCE GEORGES			10c. City, Town or Location BRENTWOOD			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 3603 43RD AVENUE					10f. Zip Code 20722			10g. Citizen of What Country? UNITED STATES			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CLERK			16b. Kind of Business/Industry RETAIL			
17. Father's Name (First, Middle, Last) TURNER MADISON						18. Mother's Name (First, Middle, Maiden Surname) DOLLY WEEKS					
19a. Informant's Name/Relationship (Type, Print) JAMES F. RIDDLE, SON						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5325 TAYLOR ROAD, RIVERDALE, MARYLAND 20737					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) FORT LINCOLN CEMETERY			Date 7/1/97		20c. Location - City or Town, State BRENTWOOD, MARYLAND		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility FORT LINCOLN FUNERAL HOME 3401 BLADENSBURG RD., BRENTWOOD, MD 20722							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death) a. Stroke</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Ischemic heart disease</p> <p>c. Dua to (or as a consequence of):</p> <p>d. Dua to (or as a consequence of):</p> </div> <div style="width: 35%; text-align: center;"> <p>Approximate Interval Between Onset and Death 3-4 days 10-15 years</p> </div> </div>											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> 4 Nursing Home <input type="checkbox"/> 5 Residence <input type="checkbox"/> 6 Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
				28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier 				29c. License number D19891				29d. Date signed (Month, Day, Year) 6/29/97			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Abraham B. DABOLA 4404 Greensburg Rd Riverdale MD 20737											
31. Date filed (Month, Day, Year) JUL 02 1997				32. Registrar's Signature 							

To Be Completed by Funeral Director

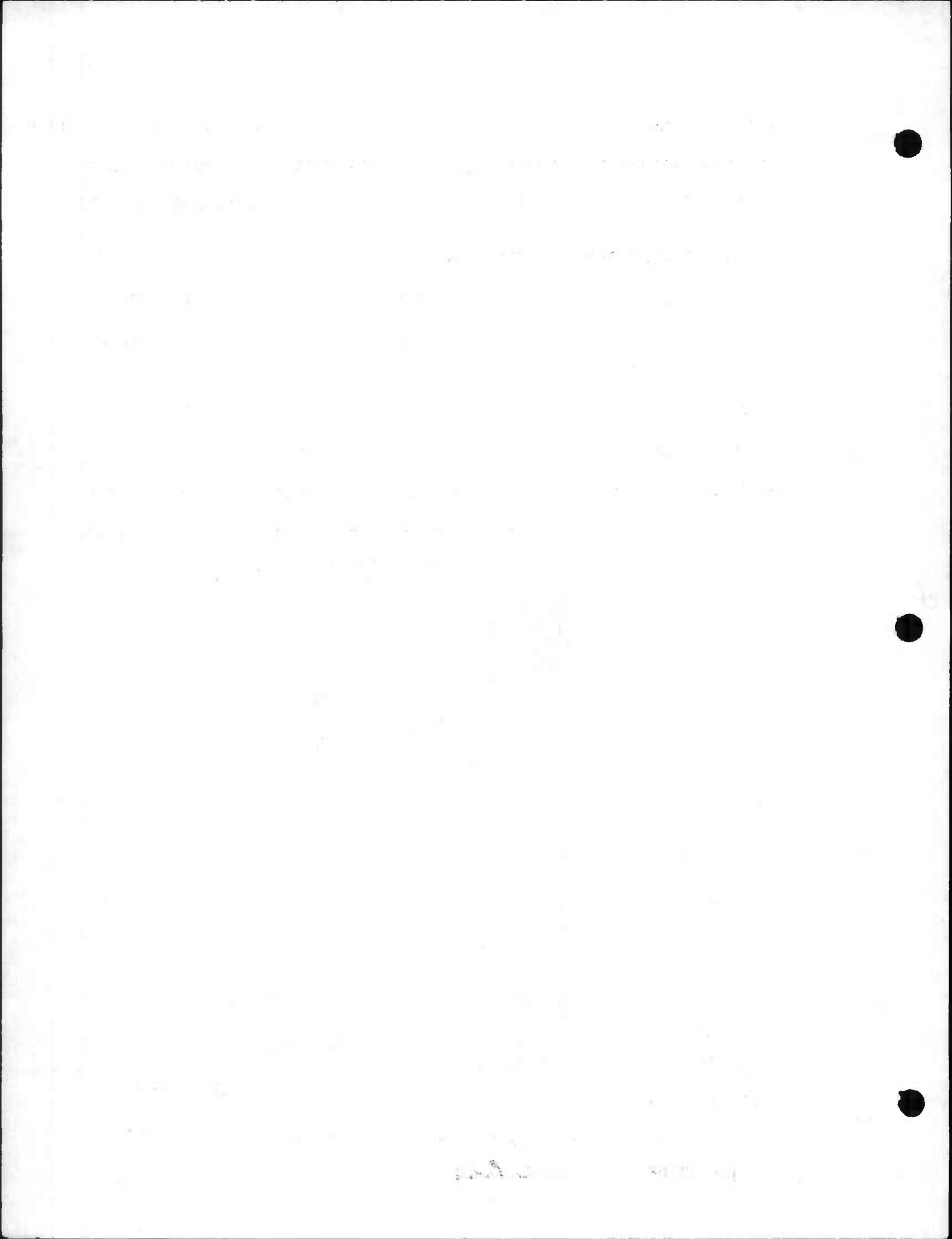
Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner



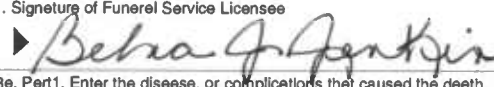
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21467

Certificate of Death

Reg. No.

Physician (Medical Examiner)	1. Decedent's Name (First, Middle, Last) JAMES DAVIS				2. Date of Death Month Day Year JUNE 27 1997		3. Time of Death 6:AM	
	4a. Facility Name (If not institution, give street and number) 5638 EMERSON ST. , APT. B4				4b. City, Town, or Location of Death BLADENSBURG		4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 578-60-1128		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 50 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JUNE 2, 47	9. Birthplace (State or Foreign Country) WASHINGTON, D.C.
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MARYLAND	10b. County PRINCE GEORGES		10c. City, Town or Location BLADENSBURG			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 5638 EMERSON ST. APT. B4			10f. Zip Code 20784		10g. Citizen of What Country? united states america		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) YRS.			16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) INSURANCE ADJUSTOR		16b. Kind of Business/Industry PRIVATE		
	17. Father's Name (First, Middle, Last) WILLIE DAVIS				18. Mother's Name (First, Middle, Maiden Surname) ROSA MARTIN			
	19a. Informant's Name/Relationship (Type, Print) ALTHEA BUNN (SISTER)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2514 PERRY ST. N.E. W.D.C. 20018				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MARYLAND NAT. CEM.		Date JULY 3, 1997		20c. Location - City or Town, State LAUREL, MD.	
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility JOHNSON & JENKINS INC. 716 KENNEDY ST. N.W. W.D.C. 20011				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Kaposi Sarcoma Due to (or as a consequence of): b. Acquired Immunodeficiency Syndrome Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death 10 months 5 years
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D27890		29d. Date signed (Month, Day, Year) 6/27/97	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark H. Snyder, MD 1011 North Capitol St NE Washington DC							
State Registrar	31. Date filed (Month, Day, Year) JUL 02 1997		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
(Medical Examiner)

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

(5)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21468

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JAMES EDWARD DANSBY SR				2. Date of Death Month Day Year JUNE 30, 1997				3. Time of Death 1:25 PM	
	4a. Facility Name (If not institution, give street and number) 2621 OXON RUN DRIVE				4b. City, Town, or Location of Death TEMPLE HILL				4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 578 70 0558		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 45 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) 4-29-52		9. Birthplace (State or Foreign Country) WASH.D.C.		10. Usual Residence of Decedent		10a. State MD		10b. County PRINCE GEORGES	
To Be Completed by Funeral Director	10c. City, Town or Location TEMPLE HILL		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 2621 OXON RUN DRIVE		10f. Zip Code 20748		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) unavail	
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry HOSPITAL		17. Father's Name (First, Middle, Last) CLEVE DANSBY		18. Mother's Name (First, Middle, Maiden Surname) MARTHA Unknown	
	19a. Informant's Name/Relationship (Type, Print) ELAINE DANSBY (WIFE)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2621 OXON RUN DRIVE TEMPLE HILLS, MD		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HARMONY MEMORIAL PARK		20c. Location - City or Town, State JULY 3, 1997 LANDOVER, MD	
	21. Signature of Funeral Service Licensee <i>Ralph Williams</i>		22. Name and Address of Facility RALPH WILLIAMS FUNERAL SVC 517 11th STREET S.E.		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. colon cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 15 months		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? NO 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>William J. Tanner</i>		29c. License number D35206	
	29d. Date signed (Month, Day, Year) July 10, 1997		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Tanner MD 11701 Livingston Rd. Suite 101 Ft. Washington Md. 20744		31. Date filed (Month, Day, Year) JUL 11 1997		32. Registrar's Signature <i>John M. ...</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21469

Item:19b per FH G-750 8/5/97 dh

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lillian I. Emmitt

2. Date of Death

Month Day Year
June 28 1997

3. Time of Death

0605 AM

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

271-09-4303

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
November 8, 1907

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Kensington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2905 McComas Avenue

10f. Zip Code

20895

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

housewife

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Joseph Bartkowski

18. Mother's Name (First, Middle, Maiden Surname)

Rosalia Koperski

19a. Informant's Name/Relationship (Type, Print)

Robert J. Emmitt

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2905 McComas Avenue, Kensington, Maryland 20895

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

6-30-97

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Deleen L. Rapp

22. Name and Address of Facility

Rapp Funeral Services, P.A.
933 Gist Avenue, Silver Spring, Maryland 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Pulmonary Edema
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 min

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ther McGary MD

29c. License number

D47092

29d. Date signed (Month, Day, Year)

June 28, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MARTIN MCGREY 9901 Medical Center Drive, Rockville MD 20850

31. Date filed (Month, Day, Year)

JUL 02 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21470

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Marjorie L. Evans				2. Date of Death Month Day Year June 27, 1997		3. Time of Death 10:15 PM														
	4a. Facility Name (If not institution, give street and number) Montgomery General Hospital				4b. City, Town, or Location of Death Olney		4c. County of Death Montgomery														
Funeral Director	5. Social Security Number 578-24-2214	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	8. Date of Birth (Month, Day, Year) July 9, 1924	9. Birthplace (State or Foreign Country) Indiana																
	Usual Residence of Decedent																				
To Be Completed by Funeral Director	10a. State Maryland	10b. County Montgomery	10c. City, Town or Location Cabin John		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																
	10e. Street and Number 7905 Woodrow Place		10f. Zip Code 20818		10g. Citizen of What Country? United States																
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White														
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home																
	17. Father's Name (First, Middle, Last) George J. Shepherd				18. Mother's Name (First, Middle, Maiden Surname) Nellie Robinson																
	19a. Informant's Name/Relationship (Type, Print) Christinia E. Roark/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13914 Bauer Court, Rockville, Maryland 20853																
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Memorial Park		20c. Location - City or Town, State Rockville, Maryland																
	21. Signature of Funeral Service Licensee <i>Michael P. Kutta</i> M00348		22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc., 7557 Wisconsin Ave. Bethesda, Maryland 20850-2805																		
	23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																				
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</td> <td>e. Sepsis</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>b. Small Bowel Infarction</td> <td>Due to (or as a consequence of):</td> <td>4 weeks</td> </tr> <tr> <td>c. Superior Mesenteric Artery Occlusion</td> <td>Due to (or as a consequence of):</td> <td>4 weeks</td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	e. Sepsis	Due to (or as a consequence of):		b. Small Bowel Infarction	Due to (or as a consequence of):	4 weeks	c. Superior Mesenteric Artery Occlusion	Due to (or as a consequence of):	4 weeks	d.	Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	e. Sepsis	Due to (or as a consequence of):																		
		b. Small Bowel Infarction	Due to (or as a consequence of):	4 weeks																	
		c. Superior Mesenteric Artery Occlusion	Due to (or as a consequence of):	4 weeks																	
		d.	Due to (or as a consequence of):																		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Failure Respiratory Failure Colon Cancer						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown															
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No															
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how Injury occurred																	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Arthur F. Woodward Jr.</i>		29c. License number D24190		29d. Date signed (Month, Day, Year) June 27, 1997															
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARTHUR F. Woodward Jr. 3416 Oldwood Ct Olney Maryland 20832																					
31. Date filed (Month, Day, Year) JUL 01 1997		32. Registrar's Signature <i>J. Davidson-Randall</i>																			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21471

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RITA DUNN EDLUND				2. Date of Death Month JULY Day 1 Year 1997		3. Time of Death 1:40 PM	
	4a. Facility Name (If not institution, give street and number) 19310 CLUB HOUSE ROAD, APT. #218				4b. City, Town, or Location of Death GAITHERSBURG		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 140-05-0002		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) Mar. 31, 1918	
	9. Birthplace (State or Foreign Country) New Jersey		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Gaithersburg	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 19310 Club House Road, #218		10f. Zip Code 20879		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher		16b. Kind of Business/Industry Elementary Education		17. Father's Name (First, Middle, Last) Patrick Dunn		
18. Mother's Name (First, Middle, Maiden Surname) Frances Sullivan		19a. Informant's Name/Relationship (Type, Print) Barbara Beall, Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 798 Kimberly Court, East, Gaithersburg, MD 20878		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		20c. Location - City or Town, State Silver Spring, MD		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD 20877		
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Lung Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death months		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) July 3, 1997		
28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D15046		29d. Date signed (Month, Day, Year) July 2, 1997		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen J. Newman, M.D., 19261 Montgomery Village Avenue, Gaithersburg, MD 20879		31. Date filed (Month, Day, Year) JUL 03 1997		32. Registrar's Signature 				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-e show any injury or other traumatic event, the Medical Examiner must be notified at 505A.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

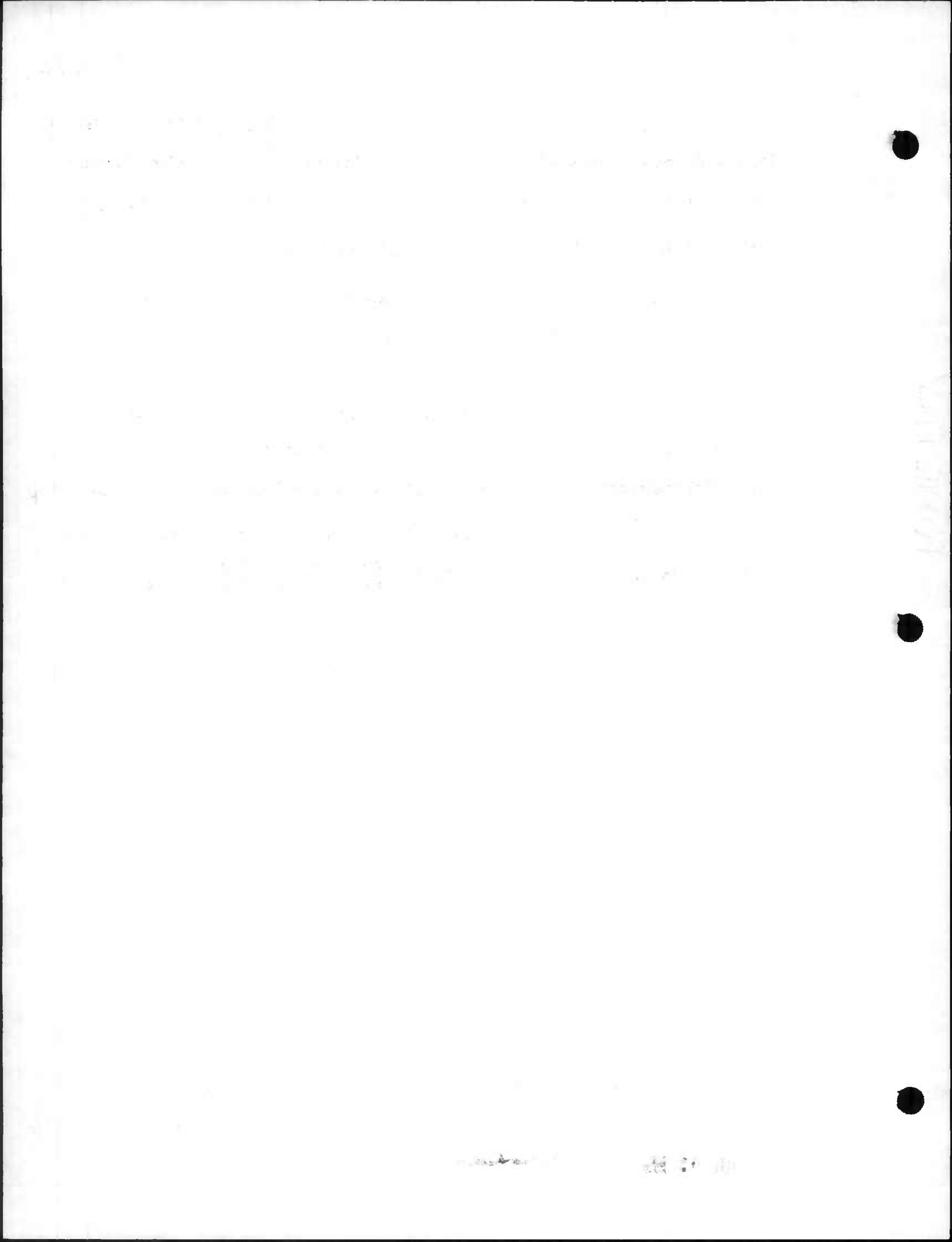
State of Maryland / Department of Health and Mental Hygiene

97 21472

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ronnie Ealy				2. Date of Death Month July 3, Day 1997 Year 1997		3. Time of Death 2:00 AM	
	4a. Facility Name (If not institution, give street and number) Doctors Community Hospital				4b. City, Town, or Location of Death Lanham		4c. County of Death Prince Georges	
Funeral Director	5. Social Security Number 254-88-1303		6. Sex 15 M 2 F		7. Age (In yrs. last birthday) 44 Yrs.		8. Date of Birth (Month, Day, Year) 12-17-52	
	9. Birthplace (State or Foreign Country) Georgia		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location College Park	
To Be Completed by Funeral Director	10d. Inside City Limits 1 X Yes 2 F No		10e. Street and Number 4714 Lakeland Road		10f. Zip Code 20740		10g. Citizen of What Country? USA	
	11. Marital Status 1 X Never Married 2 F Married 3 F Widowed 4 F Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 F Yes 2 X No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 F Yes 2 X No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accounting Technician		16b. Kind of Business/Industry Private		17. Father's Name (First, Middle, Last) Frank Ealy	
	18. Mother's Name (First, Middle, Maiden Surname) Dorothy Johnson		19a. Informant's Name/Relationship (Type, Print) Denise Roland/Sister		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3971 High Chaparral Drive, Martinez, Georgia 30907		20a. Method of Disposition 1 F Burial 2 F Cremation 3 X Removal from State 4 F Donation 5 F Other (Specify)	
Physician /Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olive Memorial Gard.		20c. Date 7/7/97		20d. Location - City or Town, State Augusta, Georgia		21. Signature of Funeral Service Licensee Nancy A. Percentie	
	22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Road, Landover, Maryland 20785		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acute Fulminant Hepatitis AIDS		23b. Did tobacco use contribute to the cause of death? 1 F Yes 2 F No 3 F Probably 4 X Unknown		23c. Approximate Interval Between Onset and Death 16 days	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	24a. Was an autopsy performed? 1 F Yes 2 X No		24b. Were autopsy findings available prior to completion of cause of death? 1 F Yes 2 F No		25. Was case referred to medical examiner? 1 F Yes 2 X No		26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 F ER/Outpatient 3 F DOA Other: 4 F Nursing Home 5 F Residence 6 F Other (Specify)	
	27. Manner of Death 1 X Natural 2 F Accident 3 F Suicide 4 F Homicide 5 F Pending investigation 6 F Could not be determined		28a. Date of Injury (Month, Day, Year) 7/3/97		28b. Time of Injury M		28c. Injury at Work? 1 F Yes 2 F No	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 F Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
	29b. Signature and title of certifier [Signature] M.D.		29c. License number 024283		29d. Date signed (Month, Day, Year) 7/3/97		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Y. [Signature] M.D. 3450 Fort Meade Road Laurel MD 20724	
State Registrar	31. Date filed (Month, Day, Year) JUL 03 1997		32. Registrar's Signature [Signature]		33. Registrar's Title [Signature]		34. Registrar's Office [Signature]	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21473

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EDYTHE M. FELS

2. Date of Death

Month Year
JUNE 29, 1997

3. Time of Death

330 AM

4a. Facility Name (If not institution, give street and number)

HEBREW HOME

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

121-03-7596

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
MARCH 4, 1917

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6121 MONTROSE RD.

10f. Zip Code

20850

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

AT HOME

17. Father's Name (First, Middle, Last)

SAMUEL MULHOFFER

18. Mother's Name (First, Middle, Maiden Surname)

EDNA YOUNG

19a. Informant's Name/Relationship (Type, Print)

CAROLYN S. TAIT/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1508 PERNELL CT., BOWIE, MD. 20716

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

CHAMBERS CREMATORY

Date

7/1/97

20c. Location - City or Town, State

RIVERDALE, MD.

21. Signature of Funeral Service Licensee

W. H. Chambers M00091

22. Name and Address of Facility

CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Alzheimer's dementia

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes, 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Burt J. Feldman MD

29c. License number

D23958

29d. Date signed (Month, Day, Year)

6/29/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Burt J. Feldman, MD, 6105 Montrose Rd., Rockville MD 20852

31. Date filed (Month, Day, Year)

JUL 01 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21474

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joseph V. Fitzpatrick Sr.				2. Date of Death Month June Day 25 Year 1997		3. Time of Death 2055	
	4a. Facility Name (If not institution, give street and number) Montgomery General Hospital				4b. City, Town, or Location of Death Olney		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 578-16-3168		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 13, 1918	
	9. Birthplace (State or Foreign Country) Washington, DC		10a. State MD		10b. County Montgomery		10c. City, Town or Location Silver Spring	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 15121 Middlegate Road		10f. Zip Code 20905		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1944-46		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) US Park Police		16b. Kind of Business/Industry Law Enforcement			
	17. Father's Name (First, Middle, Last) Joseph B. Fitzpatrick				18. Mother's Name (First, Middle, Maiden Surname) Charlotte Knibbs			
	19a. Informant's Name/Relationship (Type, Print) Frances S. Fitzpatrick				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15121 Middlegate Road, Silver Spring, MD 20905			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		20c. Date 6/30/97		20d. Location - City or Town, State Silver Spring, MD	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e. Intracranial Hemorrhage Due to (or as a consequence of): b. Intracranial Mass Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 24hrs Unknown							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial Fibrillation Chronic Anticoagulation Dilated Cardiomyopathy							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier 				29c. License number D42777		29d. Date signed (Month, Day, Year) June 26, 1997	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard Wernstein 15225 Shady Grove Road Rockville, MD 20850							
	31. Date filed (Month, Day, Year) JUN 30 1997				32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21475

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret Marie Flint				2. Date of Death Month June Day 26 Year 1997				3. Time of Death 12:50pm	
	4a. Facility Name (If not institution, give street and number) National Lutheran Home				4b. City, Town, or Location of Death Rockville				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 136-01-8919	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 85	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 19, 1912		9. Birthplace (State or Foreign Country) Baltimore		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Md.	10b. County Montgomery		10c. City, Town or Location Rockville				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 9701 Veirs Drive				10f. Zip Code 20850		10g. Citizen of What Country? US			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4or 5+) 2		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary				16b. Kind of Business/Industry Insurance			
	17. Father's Name (First, Middle, Last) Byrd W. McDonald				18. Mother's Name (First, Middle, Maiden Surname) Ernestine Besanz					
	19a. Informant's Name/Relationship (Type, Print) Thomas White				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9701 Veirs Drive Rockville Md. 20850					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Comfort Crematory		Date 6/30/97		20c. Location - City or Town, State Alexandria, Va.			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Edward Sagel Funeral Direction 1091 Rockville Pike Rockville, Md. 20852					
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction Due to (or as a consequence of): Coronary Artery Disease Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Abdominal Aortic Aneurysm Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								Approximate Interval Between Onset and Death minutes years	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Abdominal Aortic Aneurysm								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D 33138		29d. Date signed (Month, Day, Year) June 27, 1997				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Daniel A. Geller 12850 Middlebrook Rd Germantown, MD										
31. Date filed (Month, Day, Year) JUL 03 1997		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21476

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Rita Annette Foster

2. Date of Death

Month Day Year
June 29, 1997

3. Time of Death

3:30 PM

4a. Facility Name (If not institution, give street and number)

Manor Care Health Services Potomac

4b. City, Town, or Location of Death

Potomac

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

218-09-0523

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
April 30, 1907

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4521 East West Highway

10f. Zip Code

20814

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

hairdresser

16b. Kind of Business/Industry

own business

17. Father's Name (First, Middle, Last)

William Henry Cross

18. Mother's Name (First, Middle, Maiden Surname)

Lena Rebecca Meyers

19a. Informant's Name/Relationship (Type, Print)

John Gordon Foster, Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5909 Walton Road, Bethesda, Maryland 20817

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Parkwood Cemetery

Date

7-2-97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Eileen H. Rapp

22. Name and Address of Facility

Rapp Funeral Services, P.A.
933 Gist Avenue, Silver Spring, Maryland 2091023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Aspiration Pneumonia

Due to (or as a consequence of):

10 days

b. Cerebrovascular Accident

Due to (or as a consequence of):

3 months

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending
Investigation
6 ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D. Albiol

29c. License number

D 31319

29d. Date signed (Month, Day, Year)

June 30, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Loreto S. Albiol, M. D., 2 Wisconsin Circle, Chevy Chase, MD 20815

31. Date filed (Month, Day, Year)

JUL 02 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21477

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Arthur Byrd Freeman

2. Date of Death

Month Day Year
June 24, 1997

3. Time of Death

6:10pm

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

410-20-9328

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 29, 1925

9. Birthplace (State or Foreign Country)

Tennessee

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

4524 Bennion Road

10f. Zip Code

20906

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☒ Yes ☐ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
White15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
6

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Construction-Self Employed

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Carl Franklin Freeman

18. Mother's Name (First, Middle, Maiden Surname)

Mary Magdeline Tipton

19a. Informant's Name/Relationship (Type, Print)

N. Jeanne Freeman

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4524 Bennion Road Silver Spring, Maryland 20906

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Gate of Heaven Cemetery

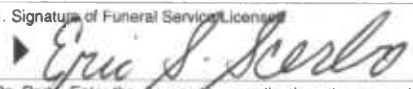
Date

6/30/97

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)a. LUNG CANCER WITH METASTASIS BONE TWO YEARS
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide28a. Date of injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D 24011

29d. Date signed (Month, Day, Year)

JUNE 25, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SARDULLAH KHAN MD 8830 CAMERON ST #502 SILVER SPRING
MD 20910

31. Date filed (Month, Day, Year)

JUN 30 1997

32. Registrar's Signature

State
RegistrarBaltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

(1)

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a discussion of the experimental design, the data collection procedures, and the statistical analysis techniques.

3. The third part of the report is a presentation of the results of the study. It includes a discussion of the findings and their implications for the field of research.

4. The fourth part of the report is a conclusion and a discussion of the limitations of the study. It also includes a list of references and a list of figures and tables.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21478

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ronald F. Frush

2. Date of Death

Month June Day 28 Year 1997

3. Time of Death

11:15P.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

3019 Chapel View Drive

4b. City, Town, or Location of Death

Beltsville

4c. County of Death

Prince George's

5. Social Security Number

217-42-2206

6. Sex

XX M 2 F

7. Age (In yrs. last birthday)

52 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) August 5, 1944

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Beltsville

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

3019 Chapel View Drive

10f. Zip Code

20705

10g. Citizen of What Country?

United States

11. Marital Status

1 Never Married 2X Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2X No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Business Owner

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Clarence F. Frush

18. Mother's Name (First, Middle, Maiden Surname)

Ara Virginia Reed

19a. Informant's Name/Relationship (Type, Print)

Barbara Frush (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as #10

20a. Method of Disposition

1 Burial 2X Cremation 3 Removal from State
4 Donation 5 Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metropolitan Crematory 6/30/1997

Date

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Donald V. Borgwardt

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.

4400 Powder Mill Rd. Beltsville, Maryland 20705

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. METASTATIC MELANOMA

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 YEAR

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2X No 3 Probably 4 Unknown

24a. Was an autopsy
performed?

1 Yes 2X No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1 Yes 2X No

25. Was case referred to medical
examiner?

1 Yes 2X No

26. Place of Death (Check only one)

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

Other:

4 Nursing Home 5X Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending
investigation
2 Accident 6 Could not be
determined
3 Suicide
4 Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?

1 Yes 2X No

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)

1X Certifying Physician

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Joseph M. Haggerty MD

29c. License number

D32407

29d. Date signed (Month, Day, Year)

June 30, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Joseph M. Haggerty, M.D. 9707 Medical Center Dr., #300 Rockville, Maryland 20850

State
Registrar

31. Date filed (Month, Day, Year)

JUL 01 1997

32. Registrar's Signature

Julia Davidson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21479

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary P. Farrell				2. Date of Death Month Day Year June 26, 1997		3. Time of Death 7:45 P.M.	
	4e. Facility Name (If not institution, give street and number) 12512 Chelton Lane				4b. City, Town, or Location of Death Bowie		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 131-10-6330	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 17, 1920	9. Birthplace (State or Foreign Country) Pennsylvania	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Prince George's	10c. City, Town or Location Bowie			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 12512 Chelton Lane			10f. Zip Code 20715		10g. Citizen of What Country? United States		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: NO		14. Race - American Indian, Black, White, etc. Specify: Caucasian	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Maker			16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) William Stanley			18. Mother's Name (First, Middle, Maiden Surname) Margaret Cronin				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Thomas J. Farrell/Husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as # 10.				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MD Veteran's Cemetery		Data 6/30/97	20c. Location - City or Town, State Crownsville, MD		
	21. Signature of Funeral Service Licensee <i>James K. Groves</i>			22. Name and Address of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Md. 20715				
	23a. (Part I) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebrovascular accident Due to (or as a consequence of): b. Insulin dependent diabetes Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 1 yr 5 yr
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
State Registrar	29b. Signature and title of certifier <i>John E. Eckberg</i>		29c. License number D35820		29d. Date signed (Month, Day, Year) 6/27/97			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Eckberg, MD 14300 Gallant Fox Lane #100 BOWIE, MD 20715							
31. Date filed (Month, Day, Year) JUL 02 1997		32. Registrar's Signature <i>John E. Eckberg</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

15


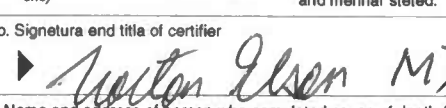
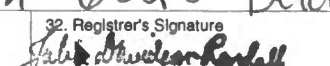
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 21480

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HOSIE FAISON				2. Date of Death Month JUNE Day 30 Year 97		3. Time of Death 9:45 PM		
	4e. Facility Name (If not institution, give street and number) MARINER HEALTH CARE				4b. City, Town, or Location of Death CLINTON		4c. County of Death PRINCE GEORGES		
Funeral Director	5. Social Security Number UNAVAILABLE		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) NOV. 3 09	9. Birthplace (State or Foreign Country) NORTH CAROLINA	
	Usual Residence of Decedent								
10a. State MD		10b. County PRINCE GEORGES		10c. City, Town or Location FORT WASHINGTON			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 3106 MARQUIS DRIVE				10f. Zip Code 20744		10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8TH College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DOMESTIC WORKER		16b. Kind of Business/Industry PRIVATE			
17. Father's Name (First, Middle, Last) MAJOR CHESTNUTT				18. Mother's Name (First, Middle, Maiden Surname) HOSIE CHESTNUTT					
19a. Informant's Name/Relationship (Type, Print) CLAUDE FAISON-SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1328 SOUTH CAROLINA AVE, S.E. WASH, D.C. 20003					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) WILSON CHAPEL CEM.		Date JUL. 8 97		20c. Location - City or Town, State MT. OLIVE, N.C.			
21. Signature of Funeral Service Licensee  276				22. Name and Address of Facility W.H. BACON FUNERAL HOME INC. 3447 14TH STREET, N.W. WASH, D.C. 20010					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Aspiration Due to (or as a consequence of): b. Neurogenic dysphagia Due to (or as a consequence of): c. Cerebrovascular accident Due to (or as a consequence of): d. Approximate Interval Between Onset and Death a. days b. months c. years									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimers Dementia									
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  MD							
		29c. License number D20362		29d. Date signed (Month, Day, Year) July 1, 1997					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Norton Elson 6525 Belcrest Rd Hyattsville MD 20782									
31. Date filed (Month, Day, Year) JUL 02 1997		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21481

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elizabeth Verta Grover				2. Date of Death Month June Day 28 Year 1997		3. Time of Death 0225	
	4a. Facility Name (If not institution, give street and number) Harford Memorial Hospital				4b. City, Town, or Location of Death Havre de Grace		4c. County of Death Harford	
Funeral Director	5. Social Security Number 212-70-5540		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) 04-24-1919	
	9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County Harford		10c. City, Town or Location Havre de Grace	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 324 Superior Street		10f. Zip Code 21078		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Home			
	17. Father's Name (First, Middle, Last) Samuel G. Curry		18. Mother's Name (First, Middle, Maiden Surname) Lottie Isadore Elliott					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Daughter Mrs. Janet E. Kilpatrick				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4004 Ady Road, Pylesville, MD 21132			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bel Air Memorial Gardn.		20c. Location - City or Town, State 7/1/97 Bel Air, Maryland		22. Name and Address of Facility Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078-3197	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078-3197			
	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last a. PROGRESSIVE RESPIRATORY FAILURE Due to (or as a consequence of): b. EMPHYSEMA Due to (or as a consequence of): c. PNEUMONIA Due to (or as a consequence of): d. CHRONIC HEART FAILURE				Approximate Interval Between Onset and Death 7 DAYS YEARS 7 DAYS ? DAYS			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. LUNG CANCER, ABDOMINAL PAIN ABDOMINAL AORTIC ANEURYSM PNEUMOTHORAX				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) June 28 1997		28b. Time of Injury M		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier M.D.					
To Be Completed by Physician/Medical Examiner	29c. License number D 31856		29d. Date signed (Month, Day, Year) 6/29/97		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D. SHARMA 1814 BELAIR RD FALLSTON, MD 21047			
	31. Date filed (Month, Day, Year) JUN 30 1997		32. Registrar's Signature 					

Handwritten text, possibly a signature or date, located in the center-right area of the page.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM#18 PER F.H. FLM#G749 7/22/97 J.A.

Certificate of Death

Reg. No.

97 21482

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Kalliope				2. Date of Death Month June Day 25 Year 97			3. Time of Death 10:50 PM		
	4a. Facility Name (If not institution, give street and number) Carriage Hills Nursing Home				4b. City, Town, or Location of Death Silver Spring			4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 577-50-7693		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 26, 1907		9. Birthplace (State or Foreign Country) Greece	
	Usual Residence of Decedent									
10a. State Maryland			10b. County Montgomery		10c. City, Town or Location Chevy Chase			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 3201 Winnett Road				10f. Zip Code 20815			10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesperson			16b. Kind of Business/Industry Retail			
17. Father's Name (First, Middle, Last) Demetrios Sangos					18. Mother's Name (First, Middle, Maiden Surname) Demetra Blakas PLAKAS					
19a. Informant's Name/Relationship (Type, Print) George James Gianakos / Son					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3201 Winnett Road, Chevy Chase, Maryland 20815					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery			Date 6/28/97		20c. Location - City or Town, State Suitland, Maryland		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. a cute myocardial infarction Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. fractured left tibia. 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year) June 6 97		28b. Time of Injury - AM		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred unknown	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Home			28f. Location (Street and Number or Rural Route Number, City or Town, State) 3201 Winnett Rd.							
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier 			29c. License number 200546		29d. Date signed (Month, Day, Year) June 26 97		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Tauber 8218 Wisconsin Ave Bethesda Md.										
31. Date filed (Month, Day, Year) JUL 01 1997			32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21483

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GLADYS GIBSON				2. Date of Death Month 6 Day 26 Year 97		3. Time of Death 12:45pm	
	4a. Facility Name (If not institution, give street and number) 11504 West Branch Dr.				4b. City, Town, or Location of Death Largo		4c. County of Death P.G.	
Funeral Director	5. Social Security Number 075-18-9188		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 98 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 9/29/1889	9. Birthplace (State or Foreign Country) West Indies
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD		10b. County P.G.		10c. City, Town or Location Largo		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 11504 West Branch Dr.				10f. Zip Code 20774		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collega (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Private			
	17. Father's Name (First, Middle, Last) Lewis Bishop				18. Mother's Name (First, Middle, Maiden Surname) Helen Branch			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Rhonda Wilson				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11504 West Branch Dr. Largo, Md. 20774			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Pine Lawn Cemetery		Date 7/1/97		20c. Location - City or Town, State Farmingdale, New York	
	21. Signature of Funeral Service Licensee <i>Janice Edwards</i>				22. Name and Address of Facility Hodges and Edwards 3910 Silver Hill RD Suitland, Md			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive heart failure Due to (or as a consequence of): b. Heart valvular disorder Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how Injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
	29b. Signature and title of certifier Doreen Blake M.D.				29c. License number D-39421		29d. Date signed (Month, Day, Year) 6/27/97	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Doreen Blake 1450 Mercantile Lane Ste 111 Largo MD 20774							
	31. Date filed (Month, Day, Year) JUN 30 1997				32. Registrar's Signature <i>John Anderson</i>			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21484

WILLA MAE GIBSON

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

6

State Registrar

1. Decedent's Name (First, Middle, Last) WILLA MAE GIBSON				2. Date of Death Month June Day 29 Year 1997		3. Time of Death 11:50 AM	
4a. Facility Name (If not institution, give street and number) DOCTORS COMMUNITY HOSPITAL				4b. City, Town, or Location of Death Lanham		4c. County of Death Prince George's	
5. Social Security Number 579-09-9507		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) May 29, 1909	
9. Birthplace (State or Foreign Country) Atlanta, GA		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Mitchellville	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 10450 Lottsford Road		10f. Zip Code 20721-2734		10g. Citizen of What Country? United	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (14 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Retired Teacher		16b. Kind of Business/Industry D.C. Public Government - Schools			
17. Father's Name (First, Middle, Last) Simeon Watts				18. Mother's Name (First, Middle, Maiden Surname) Mamie Reed			
19a. Informant's Name/Relationship (Type, Print) Vassar D. Gibson - Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 44 53rd Street, S.E., Washington, D.C. 20019			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lincoln Memorial Cemetery		20c. Location - City or Town, State Suitland, MD		20d. Date 7/3/97	
21. Signature of Funeral Service Licensee John T. Stewart III				22. Name and Address of Facility STEWART FUNERAL HOME, INC. 4001 Benning Road, N.E., Washington, D. C.			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div> <p>a. Cerebrovascular Accident Due to (or as a consequence of):</p> <p>b. Hypertension Due to (or as a consequence of):</p> <p>c. Recurrent Deep Venous Thrombophlebitis Due to (or as a consequence of):</p> <p>d. Alzheimer's Dementia Due to (or as a consequence of):</p> </div> <div> <p>Approximate Interval Between Onset and Death</p> <p>5 days</p> <p>25 years</p> <p>2 weeks</p> <p>10 years</p> </div> </div>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier Mary Ruth M. Lopez				29c. License number D46834		29d. Date signed (Month, Day, Year) July 1, 1997	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Mary Ruth Lopez, MD 7243 B Hanover Parkway, Greenbelt, MD 20770							
31. Date filed (Month, Day, Year) JUL 03 1997							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21485

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Anne E. Mc Gavigal

2. Date of Death

Month

Day

Year

6

29

97

3. Time of Death

2:00 am

4a. Facility Name (If not institution, give street and number)

Larkin-Chase Nursing Home

4b. City, Town, or Location of Death

Bowie

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

163-24-8565

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 23, 1903

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10e. State
Maryland

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

12526 Knowledge Lane

10f. Zip Code

20715

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation
(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Francis Dinsmore

18. Mother's Name (First, Middle, Maiden Surname)

Katherine Ward

19a. Informant's Name/Relationship (Type, Print)

Ann E. Lamb Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12526 Knowledge Lane Bowie Maryland 20715

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metropolitan Crematory July 3, 1997 Alexandria Virginia

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Robert E. Evans Funeral Home, Inc.

22. Name and Address of Facility

16000 Annapolis Rd. Bowie Md. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Ischemic Cardiomyopathy

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 month

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

034465

6/15/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Andrew Robin, MD 3231 Superior Lane A-C

1300 N MD 26715

31. Date filed (Month, Day, Year)

JUL 11 1997

32. Registrar's Signature

Julia Anderson Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21486

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DOO PYO HONG

2. Date of Death

Month
JulyDay
6Year
1997

3. Time of Death

0630

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

217-49-8730

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

59

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

04/16/1938

9. Birthplace (State or Foreign Country)

KOREA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WICOMICO

10c. City, Town or Location

SALISBURY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1002 ARTHUR COURT, APT. 563

10f. Zip Code

21804

10g. Citizen of What Country?

KOREA

11. Marital Status

1 ☐ Never Married2 ☒ Married3 ☐ Widowed4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes2 ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify:

ASIAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SECURITY GUARD

16b. Kind of Business/Industry

SECURITY

17. Father's Name (First, Middle, Last)

SOON KI HONG

18. Mother's Name (First, Middle, Maiden Surname)

JONG SUK LEE

19a. Informant's Name/Relationship (Type, Print)

HYANG SOON LEE HONG

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1002 ARTHUR COURT, APT. 563, SALISBURY, MD. 21804

20a. Method of Disposition

1 ☐ Burial2 ☒ Cremation3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SALISBURY CREMATORY

Date

7/8/97

20c. Location - City or Town, State

SALISBURY, MD.

21. Signature of Funeral Service Licensee

James L. Venable 00295

22. Name and Address of Facility

HINMAN FUNERAL HOME

11673 SOMERSET AVE., PRINCESS ANNE, MD. 21853

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of)

Approximate Interval Between Onset and Death

7d

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Myocardial Infarction

Due to (or as a consequence of)

7d

c. Due to (or as a consequence of)

d. Due to (or as a consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes2 ☐ No3 ☐ Probably4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Benjamin H. Meyer MD

29c. License number

D 30743

29d. Date signed (Month, Day, Year)

7/6/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

BENJAMIN H. MEYER MD, 403 QUINCY ST. SALISBURY, MD. 21801

31. Date filed (Month, Day, Year)

JUL - 7 1997

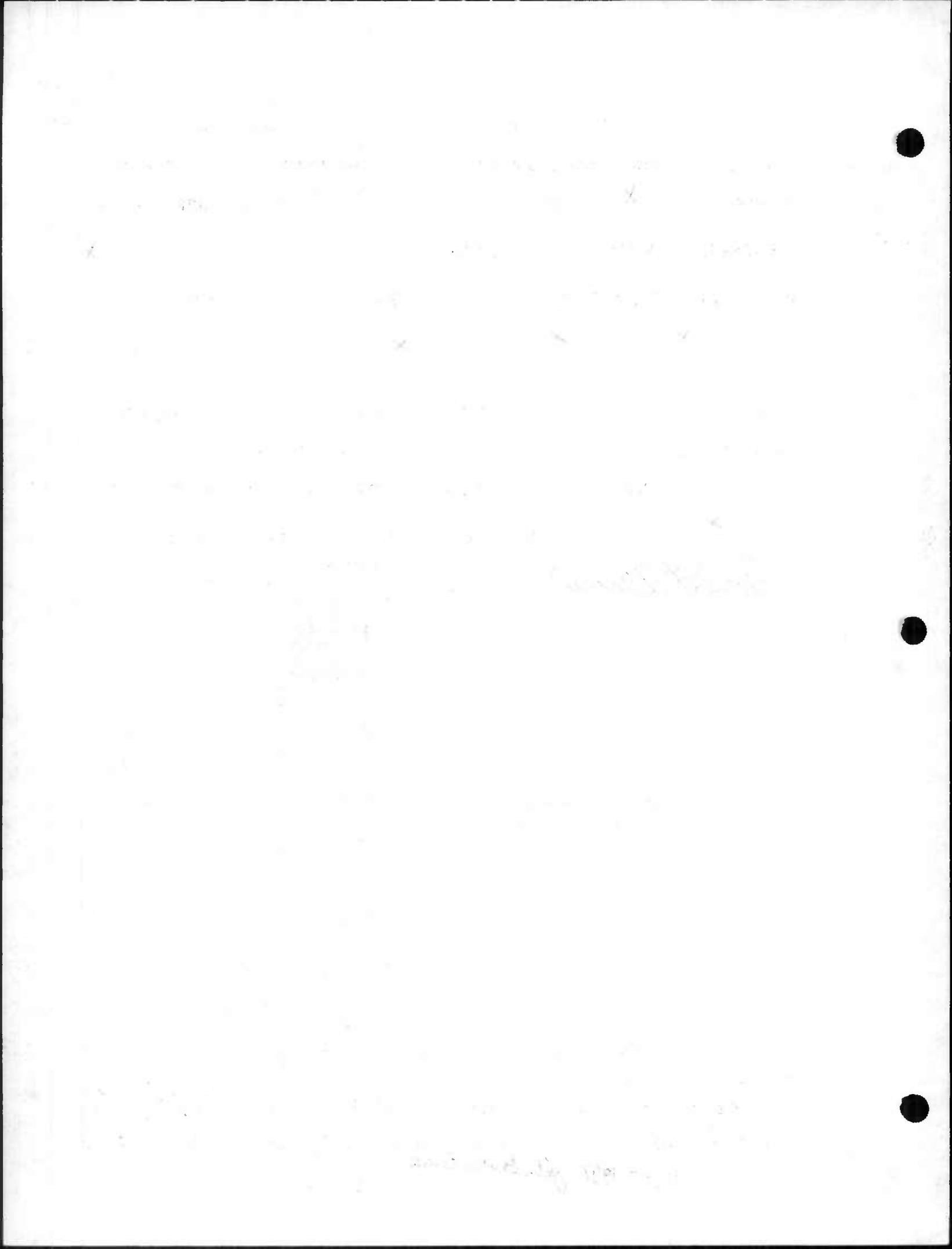
32. Registrar's Signature

John Anderson-Randall

State
Registrar

Doo Hong

Baltimore, Maryland 21215-0020



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21487

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DANIEL HORNER

2. Date of Death

Month 6 / Day 29 / Year 97

3. Time of Death

18 49

4a. Facility Name (If not institution, give street and number)

Dorchester General Hospital

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

Funeral
Director

5. Social Security Number

217-10-8928

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

77

8. Date of Birth

Month 6 / Day 27 / Year 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Dorchester

10c. City, Town or Location

Cambridge

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

405 Robbins St.

10f. Zip Code

21613

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

truck driver

16b. Kind of Business/Industry

chemical production

17. Father's Name (First, Middle, Last)

William James Horner

18. Mother's Name (First, Middle, Maiden Surname)

Emma Wesley Sinclair

19a. Informant's Name/Relationship (Type, Print)

Mrs. Deborah Faulkner-daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3659 Karen Circle, Linkwood MD 21835

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dorchester Memorial Park

Date

7-3-97

20c. Location - City or Town, State

Cambridge, Maryland

21. Signature of Funeral Service Licensee

Kenneth R. Horner Jr.

22. Name and Address of Facility

Thomas Funeral Home PA
700 Locust St. Cambridge, MD 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CHF - Congestive Heart Failure
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

one day.

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertension
Due to (or as a consequence of):

few yrs.

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☒ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☒ Outpatient☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Vinodrai Mehta

29c. License number

J15541

29d. Date signed (Month, Day, Year)

7/7/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VINODRAI MEHTA 300 AURORA STREET CAMBRIDGE, MD 21613

31. Date filed (Month, Day, Year)

JUL 7 1997

32. Registrar's Signature

Julia Davidson-Nardella

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21488

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John M. Hornick Sr.

2. Date of Death

Month Day Year
June 30, 1997

3. Time of Death

2:34 PM

4a. Facility Name (If not institution, give street and number)

Fallston Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

219-12-0164

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

7/4/24

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

PA

10b. County

York

10c. City, Town or Location

Delta

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

161 Meadow Trail

10f. Zip Code

17314

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WW 2

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

unknown

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Agriculture

17. Father's Name (First, Middle, Last)

Leonard C. Hornick

18. Mother's Name (First, Middle, Maiden Surname)

Winifred L. Ivins

19a. Informant's Name/Relationship (Type, Print)

Richard B. Hornick

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

61 Aubel Rd., Delta, PA 17314

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Mary's Cemetery 7/5/97 Pylesville, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Harkins F.H. Inc., Delta, PA 17314

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Chronic obstructive pulmonary disease

Due to (or as a consequence of):

Approximate interval between Onset and Death

3 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery disease

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

028339

29d. Date signed (Month, Day, Year)

July 1, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LINDA FUE14CH 101 E Wheel Road Bel Air MD 21015

31. Date filed (Month, Day, Year)

JUL 3 1997

32. Registrar's Signature

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

WRC
97-3493-031
OLGA J.
HALESKY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 21489

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Olga J. Halesky				2. Date of Death JUNE 24, 1997		3. Time of Death 11:54 AM	
	4a. Facility Name (If not institution, give street and number) SUBURBAN HOSPITAL				4b. City, Town, or Location of Death BETHESDA		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 217-70-7813		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 29, 1913	
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 3557 South Leisure World Blvd. #2F		10f. Zip Code 20906		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) John Javornisky		18. Mother's Name (First, Middle, Maiden Surname) Anna Gurnik		19a. Informant's Name/Relationship (Type, Print) Elaine H. McArdle		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12520 Triple Crown Road Darnestown, Maryland 20878	
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Memorial Park		20c. Location - City or Town, State 06/28/97 Rockville, Maryland		20d. Date	
	21. Signature of Funeral Service Licensee [Signature]		22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MULTIPLE INJURIES		Approximate Interval Between Onset and Death	
Medical Certification: To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 6/24/97	
State Registrar	28b. Time of Injury 1041A M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred ANOTHER CAR DRIVEN OFF CAR IN IMPACT WITH		28e. Location (Street and Number or Rural Route Number, City or Town, State) GEORGIA AVE MONTGOMERY COND	
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier [Signature]		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JUNE 25, 1997	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYANN A. KORON		31. Data filed (Month, Day, Year) JUN 30 1997		32. Registrar's Signature [Signature]				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21490

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GEORGE

PATRICK

HARLEY

2. Date of Death

Month

JULY

Day

01

Year

1997

3. Time of Death

0145

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

577-32-6128

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Jan. 25, 1930

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11616 Stewart Lane, Apt. 301

10f. Zip Code

20904

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

9

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Dry Cleaner

16b. Kind of Business/Industry

Dry Cleaning

17. Father's Name (First, Middle, Last)

George Patrick Harley, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Estelle P. Cannon

19a. Informant's Name/Relationship (Type, Print)

Gwendolyn C. Harley / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11616 Stewart Lane, Apt. 301, Silver Spring, MD 20904

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Maryland National Mem.

Date

7/5/97

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hines-Rinaldi Funeral Home
11800 New Hampshire Avenue
Silver Spring, Maryland 20904Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

SEPTIC SHOCK

Due to (or as a consequence of):

b.

PNEUMONIA

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

1 DAY

1 DAY

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RESPIRATORY FAILURE

METASTATIC LUNG CANCER

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D30112

29d. Date signed (Month, Day, Year)

JULY 01 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VIRENDRA K. SAXENA MD 7100 Deer Crossing Court, Bethesda MD 20817

31. Date filed (Month, Day, Year)

JUL 03 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21491

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Francis Alfred Hurley Jr.				2. Date of Death Month June Day 30 Year 1997		3. Time of Death 12:01 AM	
	4e. Facility Name (If not institution, give street and number) 10014 Tenbrook Drive				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 579-10-0987		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) April 30, 1916	
	9. Birthplace (State or Foreign Country) Washington, DC		10a. State MD		10b. County Montgomery		10c. City, Town or Location Silver Spring	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 10014 Tenbrook Drive		10f. Zip Code 20901		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Business Owner		16b. Kind of Business/Industry Self Employed			
	17. Father's Name (First, Middle, Last) Francis Alfred Hurley				18. Mother's Name (First, Middle, Maiden Surname) Angela Herbert			
	19a. Informant's Name/Relationship (Type, Print) Francis Alfred Hurley III				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 202 Slade Drive, Longwood, FL 32750			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State 7/2/97 Alexandria, VA		20d. Date	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e. acute myocardial infarction Due to (or as a consequence of): b. emphysema Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 15 min years							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number 708546		29d. Date signed (Month, Day, Year) June 30 1997		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) John Tauber 8218 Wisconsin Ave Bethesda MD								
31. Date filed (Month, Day, Year) JUL 01 1997				32. Registrar's Signature 				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21492

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM HILTON

2. Date of Death

Month Day Year
JUNE 27 1997

3. Time of Death

735 PM

Funeral
Director

4e. Facility Name (If not institution, give street and number)

Heartland Nursing Facility 6500 Riggs Rd

4b. City, Town, or Location of Death

Hyattsville

4c. County of Death

Prince Georges

5. Social Security Number

578-36-0093

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
May 2, 1910

9. Birthplace (State or Foreign Country)

New Kent City VA

Usual Residence of Decedent

10a. State

DC

10b. County

10c. City, Town or Location

Washington DC

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

5017 Hanna Place SE

10f. Zip Code

20019

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

☒ Yes ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
9

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

US Govt. Printing Office

17. Father's Name (First, Middle, Last)

Moses Hilton

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Macon

19a. Informant's Name/Relationship (Type, Print)

Sallie Jeter Hilton

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5017 Hanna Place SE Washington DC 20019

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetary

Date

7-1-97

20c. Location - City or Town, State

Suitland MD

21. Signature of Funeral Service Licensee

Alexander Pope Jr.

22. Name and Address of Facility

Pope Funeral Home 2617 Penn. Ave. Wash. DC 20020

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

YAS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ARTERIAL HYPERTENSION

SENIOR DEMENTIA

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

N/A

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D01852

29d. Date signed (Month, Day, Year)

JUNE 30 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAUL A DELORE MD 4203 Greensburg Rd Hyattsville MD 20781

31. Date filed (Month, Day, Year)

JUN 30 1997

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

THE END OF THE WORLD

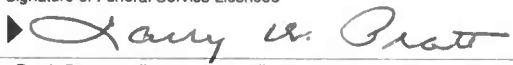
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21493

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gloris L. Hearn				2. Date of Death Month June Day 26 Year 1997		3. Time of Death 10:20 A.M.	
	4a. Facility Name (If not institution, give street and number) Prince George's Hospital Center				4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 266-72-7629		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 59 Yrs.		8. Date of Birth (Month, Day, Year) 9/21/37	
	9. Birthplace (State or Foreign Country) Florida		10a. State Md.		10b. County P.G.		10c. City, Town or Location Landover	
To Be Completed by Funeral Director	10e. Street and Number 7017 Kent Town Drive				10f. Zip Code 20785		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cosmetologist		16b. Kind of Business/Industry Cosmetology			
	17. Father's Name (First, Middle, Last) Eddie Lee Gardner				18. Mother's Name (First, Middle, Maiden Surname) Leola Odoms			
To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print) Herman L. Hearn/Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as # 10 above			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Glenwood Cem.		20c. Date 7/2/97		20d. Location - City or Town, State Wash., D.C.	
To Be Completed by Funeral Director	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility H.S. Washington & Sons, inc. 4925 Burroughs Ave., N.E.			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Malignancy Due to (or as a consequence of): c. Myeloma Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last few days few weeks for 3 years				Approximate Interval Between Onset and Death			
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				28g. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 			
	29c. License number D15214				29d. Date signed (Month, Day, Year) 6.26.97			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. JALAL Fatemi 5632 Annapolis Rd #12 BLADENSBURG Md. 20710				31. Date filed (Month, Day, Year) JUL 02 1997			
	32. Registrar's Signature 				33. Date of Death June 26, 1997			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21494

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Myrtle Lucille Johnson

2. Date of Death

Month Day Year
July 1, 1997

3. Time of Death

10:30 pm

4a. Facility Name (If not institution, give street and number)

Bel Forest Nursing & Rehab. Center

4b. City, Town, or Location of Death

Forest Hill

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

219-58-3452

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug. 25, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

705 Old Orchard Road

10f. Zip Code

21014

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Real Estate Broker

16b. Kind of Business/Industry

Real Estate
Self-Employed

17. Father's Name (First, Middle, Last)

Grover Cleveland Greer

18. Mother's Name (First, Middle, Maiden Surname)

Annie Ethel Osborne

19a. Informant's Name/Relationship (Type, Print)

M. Carl Johnson - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

705 Old Orchard Rd., Bel Air, MD 21014

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Bel Air Memorial Grdns.

Date

7-5-97

20c. Location - City or Town, State

Bel Air, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Howard K. McComas III Funeral Home, P.A.
1317 Cokesbury Rd., Abingdon, MD 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)a. Alzheimer's - Type Dementia
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

7 years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D35012

29d. Date signed (Month, Day, Year)

JULY 3, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Kevin Lynch M.D. 2 North Ave. Bel Air, Md. 21014

31. Date filed (Month, Day, Year)

JUL 3 1997

Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

97-3097-025

97-124

B.K.S

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21495

EDITH DORETTA JONES

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EDITH D JONES

2. Date of Death

Month Day Year
JUNE 6, 1997

3. Time of Death

2341PM

4e. Facility Name (If not institution, give street and number)

I-95 SOUTHBOUND OF 83

4b. City, Town, or Location of Death

Aberdeen

4c. County of Death

HARFORD

Funeral
Director

5. Social Security Number

215-32-6451

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
12-29-32

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State
MD10b. County
HARFORD

10c. City, Town or Location

ABERDEEN

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

103 PLAZA CT. APT. 3A

10f. Zip Code

21001

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Administrative Clerk

16b. Kind of Business/Industry

Civil Service

17. Father's Name (First, Middle, Last)

ELLIS

NORMAN

18. Mother's Name (First, Middle, Maiden Surname)

GRACE CHOATES

19a. Informant's Name/Relationship (Type, Print)

MYRON JONES

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

103 PLAZA CT. APT. 3A ABERDEEN, MD 21001

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Greenmont Cem.

Date

6/10/97 Baltimore, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

BEARD Funeral Home
552 Lewis St Harford de Grace, MD23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Multiple injuries
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

ROADWAY

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☒ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)

6-6-97

28b. Time of
Injury

2313 M

28c. Injury et
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Driver in multi vehicle collision

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

Interstate

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

I-95 S'bound at mile marker 83

29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

JUNE 8, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

AMORXON

111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

JUN 26 1997

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

21A

From the ... of the ...
the ... of the ...
the ... of the ...
the ... of the ...

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 21496

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Nettie Marion Jones

2. Date of Death
Month Day Year

June 16 1997 8:30 P.M.

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

HARFORD Mem. Hospital

4b. City, Town, or Location of Death

Harrode Grace

4c. County of Death

HARFORD

5. Social Security Number

218-34-2175

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov 11, 1911

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

MD

10b. County

HARFORD

10c. City, Town, or Location

Aberdeen

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

430 Baltimore

10f. Zip Code

21001

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Housekeeping

17. Father's Name (First, Middle, Last)

PRESTON UNK

18. Mother's Name (First, Middle, Maiden Surname)

Lizzie Marion

19a. Informant's Name/Relationship (Type, Print)

Jimmy Lee Jones

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

430 Baltimore St Aberdeen, MD 21001

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT Calvary Cem. 6-20-97

Date

6-20-97

20c. Location - City or Town, State

Aberdeen

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

BEARD FUNERAL HOME
552 Lewis St Harrode de Grace, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hypotension

Due to (or as a consequence of):

b. Intestinal Obstruction probably

Due to (or as a consequence of):

c. metastatic

Due to (or as a consequence of):

d. Hypovolemic Dehydration

Approximate Interval Between Onset and Death

2 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Carcinoma of Stomach
Moderate to Severe Cachexia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

Not applicable

28b. Time of Injury

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28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

Not applicable

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Not applicable

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Not applicable

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D19583

29d. Date signed (Month, Day, Year)

June 16, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MANUEL M. LAZARIN MD

8 Law Street, Aberdeen, Maryland 21001

31. Date filed (Month, Day, Year)

JUN 26 1997

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21497

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Gladys B. JETTMAR</i>			2. Date of Death Month <i>June</i> Day <i>29</i> Year <i>1997</i>			3. Time of Death <i>12:05 AM</i>			
	4a. Facility Name (If not institution, give street and number) WASHINGTON ADVENTIST HOSPITAL			4b. City, Town, or Location of Death TAKOMA PARK			4c. County of Death MONTGOMERY			
Funeral Director	5. Social Security Number <i>578-26-0241</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) <i>72</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>JULY 3, 1924</i>		9. Birthplace (State or Foreign Country) MINNESOTA	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD.		10b. County PRINCE GEORGES		10c. City, Town or Location ADELPHI				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 2300 SEMINOLE ST.				10f. Zip Code 20783		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <i>2</i>				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE			16b. Kind of Business/Industry AT HOME		
	17. Father's Name (First, Middle, Last) HUGH BOTTELSON					18. Mother's Name (First, Middle, Maiden Surname) HELEN CAMPBELL				
	19a. Informant's Name/Relationship (Type, Print) EMIL F. JETTMAR/HUSBAND					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS ITEM #10				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) CHAMBERS CREMATORY			Date 7/1/97		20c. Location - City or Town, State RIVERDALE, MD.	
	21. Signature of Funeral Service Licensee <i>W.W. Chambers</i> MO0091					22. Name and Address of Facility CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. Non Hodg Kins Lymphoma</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>b. c. d.</i> Due to (or as a consequence of): Due to (or as a consequence of):									
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Severe Anemia</i> <i>Leucopenia</i> <i>Thrombocytopenia</i> <i>Respiratory Failure</i> <i>Hypoproteinemia</i>										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>[Signature]</i>					29c. License number <i>D 42403</i>		29d. Date signed (Month, Day, Year) <i>6/30/97</i>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>RAJ MATHEW Washington Adventist Hospital, TAKOMA PARK, MD.</i>										
31. Date filed (Month, Day, Year) <i>JUL 01 1997</i>					32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21498

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jean S. Jerman				2. Date of Death Month June Day 25 Year 1997		3. Time of Death 5:14 AM	
	4a. Facility Name (If not institution, give street and number) 15100 Interlachen Drive Apt. #1020				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 578-40-8592		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 67 Yrs.		8. Date of Birth (Month, Day, Year) June 16, 1930	
	9. Birthplace (State or Foreign Country) Washington, DC		10e. State MD		10b. County Montgomery		10c. City, Town or Location Silver Spring	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 15100 Interlachen Drive # 1020		10f. Zip Code 20906		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Business Office Manager		16b. Kind of Business/Industry Telecommunications			
	17. Father's Name (First, Middle, Last) Rudolph E. Stromberg				18. Mother's Name (First, Middle, Maiden Surname) Anna LeDane			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Laird S. Jerman, Jr.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Showbarn Court, Damascus, MD 20872			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		Date 6/27/97		20c. Location - City or Town, State Suitland, MD	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Andrew J. Cole				22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901			
	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Ovarian carcinoma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							Approximate Interval Between Onset and Death 15 months
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier Joseph Kaplan				29c. License number D 35635		29d. Date signed (Month, Day, Year) June 25 1997	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) JOSEPH KAPLAN 18111 Paine Philip Dr. OLNEY, MD 20832							
State Registrar	31. Date filed (Month, Day, Year) JUN 26 1997				32. Registrar's Signature John Davidson-Randall			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21499

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Elson Johnson

2. Date of Death

Month Day Year
June 25, 1997

3. Time of Death

3:00 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

14345 Georgia Avenue, #104

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

367-38-9762

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

58 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
August 13, 1938

9. Birthplace (State or Foreign Country)

Michigan

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

14345 Georgia Avenue, #104

10f. Zip Code

20906

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates: 1962-64

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

9

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Electrical Engineer

16b. Kind of Business/Industry

Aerospace

17. Father's Name (First, Middle, Last)

Tommie Lee Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Naomi Electa Harris

19a. Informant's Name/Relationship (Type, Print)

Yeva Maria Johnson (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 40165, San Francisco, California 94140

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

6-29-97

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Carol A. Delm

22. Name and Address of Facility

Rapp Funeral Services, P.A.
933 Gist Avenue, Silver Spring, Maryland 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

Immediate

b. Hypertension

Due to (or as a consequence of):

20 years

c. Chronic Renal Failure

Due to (or as a consequence of):

5 years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Frank C. Blackburn, M.D.

29c. License number

D01601

29d. Date signed (Month, Day, Year)

June 26, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frank C. Blackburn, M.D., 5401 Western Avenue, NW, Washington, D.C. 20015

31. Date filed (Month, Day, Year)

JUN 30 1997

32. Registrar's Signature

Julia Davidson-Randall

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 21500

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Monica F. Jones</i>				2. Date of Death Month <i>June</i> Day <i>27</i> Year <i>1997</i>		3. Time of Death <i>1350</i>	
	4e. Facility Name (If not institution, give street and number) <i>SHADY GROVE ADVENTIST HOSPITAL</i>				4b. City, Town, or Location of Death <i>ROCKVILLE</i>		4c. County of Death <i>MONTGOMERY</i>	
Funeral Director	5. Social Security Number <i>090-03-5576</i>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>91</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>Sept. 23, 1905</i>	
	9. Birthplace (State or Foreign Country) <i>New York</i>		10e. State <i>Maryland</i>		10b. County <i>Montgomery</i>		10c. City, Town or Location <i>Rockville</i>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <i>1235 Potomac Valley Road</i>		10f. Zip Code <i>20850</i>		10g. Citizen of What Country? <i>United States</i>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Administrative Assistant</i>		16b. Kind of Business/Industry <i>Federal Reserve System</i>			
	17. Father's Name (First, Middle, Last) <i>Charles Irving Freeman</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Genevieve Maxner</i>			
	19e. Informant's Name/Relationship (Type, Print) <i>Renee I. Fox (attorney)</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1725 K Street, NW, #1202, Washington, DC 20006</i>			
	20e. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Chesapeake Crematory</i>		20c. Location - City or Town, State <i>6-28-97 Beltsville, Maryland</i>			
	21. Signature of Funeral Service Licensee <i>Eileen H. Rapp</i>				22. Name and Address of Facility <i>Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910</i>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>Aspiration pneumonia</i> Due to (or as a consequence of): <i>dysphagia</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>dementia</i>							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>dementia</i>							
	23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <i>David A. Bloss MD</i>		29c. License number <i>D23911</i>		29d. Date signed (Month, Day, Year) <i>June 27, 1997</i>			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>David A. Bloss MD 9410 Old Georgetown Rd. Bethesda, Md. 20814</i>							
	31. Date filed (Month, Day, Year) <i>JUL 02 1997</i>		32. Registrar's Signature <i>Julia Davidson-Randall</i>					

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

